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ABSTRACT

Through joint efforts of mental health and education professionals, a school-based therapeutic/educational program for seriously emotionally disturbed children, some of whom had additional identified disabilities such as mental retardation, was initiated with 15 students (ages 8-13). The educational component of the program was based on an individualized education program (IEP) for each student, while the therapeutic component consisted primarily of group therapy treatment focusing on social skills, insight groups, and expressive activities. A parent advocacy group was formed, and community awareness activities planned and executed. Posttest evaluations following 6 months of program operation indicated that 12 of the 15 students met the target academic goal of increasing their academic achievement levels by 6 months. Improvement in levels of behavioral functioning based on identified social/emotional objectives showed similar improvement for 12 of the 15 students. Among conclusions drawn from the initial program effort were (1) that the primary population for a latency aged program of this type is single-diagnosed seriously emotionally disturbed students rather than those with multiple disabilities, and (2) that better definition of the role of the mental health worker in the classroom was needed. (JW)

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Center for the
Advancement of Education
Ed.D. Program

A School-Based Therapeutic/Educational Program For Severely Disturbed Latency Aged Children

by

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A School-Based Therapeutic/Educational Program For Severely Disturbed Latency Aged Children

MAR 2 5 1988

by

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A Practicum II Report Presented to the Ed.D. Program
in Early and Middle Childhood
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education

NOVA UNIVERSITY

1988

PRACTICUM APPROVAL SHEET

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Approved:

3.28.88
Date of Final Approval of Report

Jo Ellen Salce Rogers
Jo Ellen Salce Rogers, Ph.D., Adviser

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ABSTRACT

AUTHOR Shelby, Madge E.

TITLE A School-Based Therapeutic/Educational Program For Severely Disturbed Latency Aged Children

DATE 1988, March

DESCRIPTORS *Behavior: Change/Disorders/Modification/Patterns/Problems, *Emotional: Adjustment/Problems, *Social: Adjustment/Problems, *Special Schools: Nontraditional Education/Educational Planning/Program Design/Comprehensive Programs/Day Programs, *Models: Psychiatric Services/Psychological Services/Public Schools/Mental Health Programs, *Therapeutic Environment: Psychoeducational Methods/Therapists Role/Drug Therapy.

This practicum addresses the problem of the unmet needs of behaviorally/emotionally disturbed children and the strong commitment by Special Education and Mental Health Agencies to develop a full continuum of treatment and education within the school site. Mental Health Agencies have the same obligation to provide therapeutic support services to these children as schools have to provide them with education and related services. Research evidence bears out the need for innovative mental health treatment approaches and alternative schooling to more conclusively deal with the neglected mental health problems of the young.

The practicum goals were (1) to increase social skills of the target students; (2) to decrease their behavioral disorders; and (3) to improve their academic performance. The establishment of a comprehensive school-based therapeutic/educational program for severely emotionally disturbed latency aged children was chosen as the solution to the problem. Evaluations were made on the basis of a student sociometric rating scale, therapist goal attainment scale, and standardized achievement tests. Implementation of this practicum included correlating the educational and therapeutic components in a school setting, using a team approach which involved students, parents and staff. A parent advocacy group was formed and direct links were established with Children Service Agencies. Effective community relations were developed through a series of public activities.

Standards of performance were met for all objectives. Post ratings revealed significant increase in social skills and significant decreases in behavior disorders. Considerable gains were made in academic achievement.

Chapter I

INTRODUCTION

Description of Community

The setting for this practicum was a small county located in southwestern Pennsylvania. The southern boundary is the Mason-Dixon Line, existing on the common border between Pennsylvania, West Virginia, and Maryland. To the east stand the heavily forested slopes of Appalachia. To the west are the lowlands that spread out to the Monongahela River. The 802.1 square mile area has a population of 159,417 the majority of which lives in the western two-thirds of the county a rural (non-farm) mountainous village and suburban sprawl area (1980 census data). Resources of coal, oil, and natural gas are present, however, these resources are not produced as abundantly or economically as in the past (Economic Profile, 1982). The Pennsylvania County Data Book (1982) describes this county as depressed economically, socially, culturally, and educationally. In early 1983, unemployment rose to 28.6%, the poorest county record in the state (County Office of Employment Security, 1983). Of the total population, 11.2% are receiving cash assistance and 17% are receiving food stamps (Department of Public Welfare, 1985). The illiteracy rate (22.2%) is the highest in the Commonwealth of Pennsylvania (National Library Association, 1986).

Widespread unemployment, substandard housing, and the general sense of hopelessness have all contributed to parent-child conflict, child neglect, and ultimately emotionally disturbed children.

An agency that addresses these human functioning problems is the County Community Mental Health Center whose mission is to provide quality care to the mentally disabled of all ages in this area. This agency began operations in 1968. The Center serves both as a Base Service Unit which is a central contact point for all persons admitted into the County's Mental Health/Mental Retardation Program, and as an outpatient clinic for community-based care and treatment services. As a private, non-profit organization, the Center operates under the direction of an administrative board of directors and an executive director. In addition, the Center also receives more administrative and fiscal direction from the Administrator's Office of the County Program. In this way, both fiscal accountability and compliance with state and federal regulations is assured.

The existing MH/MR services, as mandated for County programs in the Mental Health Act of 1966 include:

. Outpatient services
. Partial Hospitalization (Adult and Adolescent)
. 24-Hour Emergency Services
. Aftercare
. Specialized Rehabilitation and Training
. Interim Care for the Mentally Retarded
. Unified Intake

Beginning with a Federal Initial Operation Grant, the Center has experienced rapid growth over the past 18 years. Funding of the Center during the fiscal year 1985-1986 included 54% in state and federal government sources, 15% in local government support and 31% in fee income.

The adolescent human functioning problems are addressed in the Center's Partial Hospitalization for Adolescent Services and Education Program. Called PHASE, this program originated in 1982 as an authorized service program of the County Community Mental Health Center, Inc., in affiliation with the County MH/MR Program, and is fully serviced academically by the Intermediate Unit's Socially and Emotionally Maladjusted Division.

With the increased number of emotionally disturbed children in this area, the Center has been receiving more and more requests for a comprehensive daytime treatment program for the latency aged children, 8 through 13 years of age.

Author's Work Setting and Role

Over the past 14 years, the writer's work experience has included: Regular teacher K-6, Special Education teacher, Gifted Itinerant Resource teacher, primary and intermediate levels, Learning Disabled teacher, self-contained, as well as, Resource Room teacher K-6, Socially and Emotionally Maladjusted teacher.

Prior to entering the field of education the writer held the position of Director of Medical Records at three hospitals in the states of Wisconsin and Pennsylvania. Involvement with the Children's Unit at this site revealed an apparent need for a correlation between the Center's therapists and the public school teachers. Thus, in addition to serving as the Center's Director of Medical Records, the writer is also a member of the Children's Unit Mental Health Team serving as Consultant and Therapeutic Educator.

As director of Medical Records, the writer bears the primary responsibility for protection and disposition of the client's medical record which includes departmental based records of Children and Youth Services, Adult Records, and Partial Out-Patient Program. An additional responsibility is staff development.

As Consultant for the Children's Unit, which services 723 children annually, a sound background in Early and Middle Childhood regular and special education is a prerequisite. Further duties require administration and interpretation of clinical data from psychological testing and psychiatric interview and to relate effectively to consultants from social work, clinical psychology and psychiatry.

As Therapeutic Educator, the writer functions as academic tutor to children referred by individual therapists as a supportive part of the treatment plan. Teaching disturbed children is neither regular teaching nor is it psychotherapy. Rather it is a melding of elements of each. The demands are so unique and the concept so young that a new term, "therapeutic education" has been developed to describe the process.

Education can and often does, play an important role in the treatment program for the emotionally disturbed child, but education is conceived as a part of treatment, as a support to treatment, rather than an end in itself.

Chapter II

STUDY OF THE PROBLEM

Problem Description

Mental Health, or the lack of it, is widely recognized as a most pressing social problem of the last few decades. The 1980 census indicates the school age population in the United States is 40 million (27 million elementary and 13 million secondary students). Today at least 10% of our school age population need psychiatric help. In the schools, a large majority of the 10% need supportive services only but some will need a more intensive special education (Wallace, 1983).

Data on the numbers of students served for each handicapping condition were available in the mandated annual reports to Congress in the implementation of PL 94-142, The Education for All Handicapped Children Act of 1975, by the U.S. Department of Education. For the 1978-1982 time period more than 90% of the students needing intervention were classified in four handicapping conditions (i.e., Slow Learner, Learning Disabled, Mentally Retarded, and Emotionally Disturbed).

According to the Council for Children with Behavioral Disorders (1987) there are a half million severely disturbed youngsters who are excluded from school by expulsion or refusal of admission. Among them will be the child who needs full-time intensive treatment. Many of them are

in the regular classroom now, retreating further from normal social relationships or disrupting the school system. Treatment of these children has changed radically during the last two decades. The prevelance of behaviorally disordered students who receive tranquilling and antidepressant medication is remarkably high. Therefore, individuals who work with these children in educational settings need to be familiar with the drugs prescribed.

Drug therapy is the most common medical intervention for behavior disorders (Cullinan, Epstein, and Loyd, 1983). Surveys show that most special education teachers have had experience with students on medication for the control of behavior, however, teachers generally feel that their knowledge about drug therapy is insufficient (Gadow, 1986). Because psychotropic drugs are capable of producing both beneficial and unintended side effects (Conners and Werry, 1979), physicians and child psychiatrists who prescribe medication need information regarding observed effects from parents and school personnel in order to best serve children and adolescents on medication. Epstein and Olinger (1987) present the following basic information about drug therapy:

Psychotropic Drugs	Desired Effects	Possible Side Effects
Stimulants:		
Ritalin Cylert Dexedrine Benzedrine	Improve attention span; decrease disruptive, inappropriate, and impulsive behavior	Reduced appetite and insomnia most common; also possibility of sadness, irritability headaches, nervous tics
Antidepressants:		
Elavil Tofranil	Treatment of enuresis and school phobia, reduce hyperactivity and depression	Dry mouth, nausea, and reduced appetite most common; insomnia tremor, high blood pressure, heart malfunctioning possible at high dosages, overdose may lead to poisoning
Antipsychotics:		
Thorazine Haldol Navane Mellaril Stelazine	Reduce maladaptive behaviors such as aggression and hyperactivity; reduce schizophrenic symptoms such as delusions and hallucinations	Impaired cognitive performance, lethargy, apathy, dry mouth, weight gain, increased appetite, enuresis, extra-pyramidal syndromes (motor disorders)
Lithium	Treatment of mania, bipolar affective disorder, and other major mood disturbance	Nausea, fine tremor, excessive need to urinate, loose stools, signs of toxicity and dizziness, vomiting, diarrhea, shaking, sleepiness, slurred speech

Because drug therapy is a fairly common medical intervention for behavior disorders, Cullinan et al. (1983) offers guidelines for collaborating with the medical community, teachers, and parents on behalf of students who take psychotropic medication:

1. Become informed about drug therapy.
2. Follow school policy for the administration of prescribed medications at school.
3. Set up a system of communication with physicians and parents.
4. Collect data on target behaviors before, during and after any drug therapies are used.
5. Monitor side effects. Adjust school schedules and curriculum if necessary during the titration phase.
6. Discuss drug therapy directly with students, using language at their level.
7. Parent groups may be used to teach behavior management skills.
8. Continue to provide the best educational program possible, and provide related services where indicated.

Drug therapy presently is an expedient and popular form of treatment for hyperactive behavior. Nevertheless, drug manufacturers have been accused of pushing their products to physicians who in turn too easily prescribe the medication as shown by Axelrod and Bailey (1979).

Criticism of such practices may be justified. However, it must be understood that parents and educators remain the originators of medical intervention for a child's behavior. These individuals must then be responsible for ensuring that adequate and accurate information be given to the medical authorities.

Sinclair, Forness, and Alexson (1985) investigated the relationship between psychiatric and educational classifications for a sample of 350 children, aged 6 years to 14 years, referred to a psychiatric outpatient department for school learning problems. The findings of this study suggests that the use of psychiatric diagnosis in conjunction with psychoeducational test data is insightful, however, it does not appreciably translate into specific educational placements any better than the use of psychoeducational test data alone.

Behaviorally disturbed children have been described as those requiring special educational treatment to effect their personal, social or educational readjustment. What has never been described is the nature of the special educational treatment required: in what ways should the curriculum for disturbed children differ from that provided for the non-disturbed and how does special educational treatment differ from clinical treatment? Wilson, Evans, Dawson and Kiek (1977) respond to this inquiry in stating that the student's insight into personal and social problems is seen as important but less dependent on psychotherapy or group work than might have been expected. There is increasing regard for the contribution of the academic curriculum to the treatment program and schools are seeking ways of setting up objectives and establishing incentives to encourage educational progress.

Increased use of psychiatric diagnostic workups has occurred in determination of children's eligibility for special education or related services (Sinclair, Forness, Alexson, 1985). There is a growing trend in special education to rely on other professional disciplines or agencies for assistance in the diagnosis process. Recent issues of special education journals have focused upon the relationship of physicians to special education and interagency cooperation between public schools and mental health agencies (Guralnick, 1982; Martinson, 1982).

Traditional psychoeducational evaluation for children with behavior problems typically consists of developmental and school histories, parent interview, intelligence and personality testing, teacher interview and/or observation of the child in the classroom, teacher ratings or evaluations and, on increasingly frequent occasions, medical or psychiatric examination (Forness, 1983; Hewett and Forness, 1984; Kazdin, 1983). In actual practice it is questioned whether this approach bears any relationship to classroom programming (Schenck, 1980; Sinclair, 1980; Sinclair and Kheifets, 1982; Thurlow and Ysseldyke, 1982; Williams and Coleman, 1982). Kazdin (1983) argues that certain educational or behavioral views of clinical disorders fail to consider certain problems of the child in his own context, such as family stability, social relationships, developmental history, classroom behavior, learning style, and attitudes.

Teaching disturbed children is neither regular teaching nor is it psychotherapy. Distinction between teacher and therapist are readily observable:

The teacher-child relationship is seldom interpreted. The therapist-child relationship is almost always interpreted.

The teacher needs to know a child's healthy defense patterns and support them. The therapist tries to give insight into them.

The teacher helps the child with reality pressures. The therapist frees the child from internal drives.

The teacher is concerned with the "situational" present. The therapist is concerned with the "historical" past (Hirschberg, 1977).

In the past, school systems restricted their effort to the "normal" child. Gradually, however, group after group of children with special needs have been redefined as teachable within the regular school system. Now mainstreaming legislation is requiring schools to reintegrate emotionally disturbed youths in the school system. Unlike many other handicapped children, aggressive, acting-out children may need to be placed in a separate educational environment. They may be too assaultive and destructive for traditional school programs. The most appropriate program may thus be one that combines both therapeutic and educational functions. This type of alternative day school program has significant

implications for both treatment and prevention (Kennedy, Mitchell, Klerman, and Murray, 1976).

Problem Documentation

Long and McQueen (1984) examined the effect of socio-demographic, mental health resource, and school system variables on the identification and treatment of children as emotionally disturbed. The major finding in this study revealed that emotionally disturbed children are significantly underdetected and underserved nationally in public school systems. Further, the results indicate that the attitudes of school system officials and the community in general, as well as the availability of mental health professionals, determines whether school systems detect emotionally disturbed children. When such children are detected, more specialized and expensive services are provided in school districts with higher percapita income, school budget, and proportion of mental health professionals.

Of prime concern in this local community mental health center, in their effort to appropriately serve latency aged children with serious emotional disturbance, is the need of a triadic partnership which can only be attained by the combined efforts of the therapist,teacher and parent in a cooperative environment. The Center's 1981-1982 Annual Plan notes as a priority for mental health services

"to develop and expand quality mental health services for children and youth."

The Intermediate Educational Unit which services 2,000 handicapped students in this county and 120 socially/emotionally disturbed students, indicates the I.U.'s major unmet need in education and mental health services is to provide additional services to severely disturbed children.

With this joint concern of both service agencies, a steering committee was formed to investigate possible solutions. This committee included representatives from the Mental Health Unit and the Intermediate Educational Unit. A program director was employed to be responsible for the tasks associated with compiling a needs assessment, planning the program, conceptualizing and operationalizing the objectives, monitoring the expenditure of funds, supervising the field operations, providing for the integration and coordination of tasks, and serving as liaison to other agencies and the community in general.

The steering committee and the program director began plans for an assessment program for both the therapeutic and educational components to secure accurate needs information about the target population.

The Rates-Under-Treatment approach was chosen by the community mental health center. The RUT approach (NIMH, 1977) to needs assessment is based on a descriptive enumeration of children who have utilized the services. The underlying assumption is that the needs of the target population can be estimated from a sample of children who have received care or treatment.

A RUT approach to needs assessment was proposed by Moor, Bloom, Gaylen, Pepper, Pettus, Willis, and Bahn (1977) who suggested that agencies can secure useful information for program purposes by analyzing such areas as types of services being provided, referral sources, and patient characteristics. RUT studies are widely used to make estimates of health needs and service patterns of target populations.

The Center's outpatient services includes approximately 3200 clients of which 303 (9.5%) are over 65 years of age, 2174 (68%) are between the ages of 18 and 64, and 723 (22.5%) are children below the age of 18.

Referrals from service agencies (including school districts) compile approximately 20% of the population. Approximately 15% of the population are referred following

hospitalization. The remainder (65%) are self referred, including parents and walk-in clients. The primary entry point (referral from the professional community, parent and schools) is supplemented by internal agency referrals.

The target population served in the Therapeutic Services program include the following diagnoses from the Diagnostic and Statistical Manual of Mental Disorders (DSM III):

Axis I (The clinical psychiatric syndrome)

Attention Deficit Disorder:

Without Hyperactivity (314.00)

With Hyperactivity (314.01)

Axis II (Personality and developmental disorders)

Disturbance of conduct	(312.00)
Intermittent explosive disorder	(312.34)
Unspecified disturbance of conduct	(312.90)
Disturbance of emotions specific to childhood or adolescence	(313.00)
Oppositional disorder	(313.81)
Unspecified emotional disturbance of childhood or adolescence	(313.90)
Hyperkinetic conduct disorder	(314.2)
Mixed development disorder	(315.50)

Although a more comprehensive review of DSM III is available in Forness and Cantwell (1982), it should be mentioned that in this needs assessment two diagnostic axes were used to represent the psychiatric diagnosis of each child. DSM III Axis I and Axis II diagnoses data was gathered from the mental health center's medical records.

Of the 723 children's population, 150 were diagnosed as Attention Deficit Disorder with Hyperactivity (314.01); of these, 75 also had Axis II diagnoses; of these, 36 were classified as severely disturbed on the Level of Functioning (LOF) goal attainment scale (Appendix A).

The Referral-Questionnaire approach was chosen by the Intermediate Educational Unit. The R-Q approach to needs assessment (NIMH, 1977) is based primarily on the needs of the children serviced by the Intermediate Unit who are most in need of multiple services and whose needs are not being met by existing services. The underlying assumption of this approach is that it is possible to make useful estimates of the educational needs and social well-being of the target population by analyzing statistics regarded as indicators of need.

The Intermediate Unit's educational services include approximately 6,000 elementary and secondary students in a tri-county area; 2,000 of which reside in this county. In the six school districts serviced by the I.U., there are twelve classrooms for the socially/emotionally disturbed students (8 elementary and 4 secondary). The total population of the elementary SED classes is 120 (approximately 15 students per class).

Referral for admission to the SED class is made by the regular classroom teacher to the multidisciplinary team. Many states have replaced a single individual or "gatekeeper", usually the school psychologist, with a committee for making special education placement and programming decisions (Pryzwansky, 1981). A team, or group of persons, instead of one or two professionals is expected to be involved in both the assessment of disabilities and the planning of schooling for the exceptional child. Specifically, Section 121 a. 532(e) of Public Law 94-142 states, "The evaluation is made by a multidisciplinary team or group of persons, including at least one teacher, or other specialist, with knowledge in the area of suspected disability." Section 121 a. 533 (3) further requires that each public agency shall "insure that the placement decision is made by a group of persons, including persons knowledgeable about the

child, the meaning of the evaluation data, and the placement opinions."

The target population served in the Educational Services program include the following Behavior Problem Characteristics from the Behavioral Disorders Council for Children with Behavioral Disorders (CCBD).

Behavioral Charcteristics Noted:

Overly Active
Reading (Underachievement)
Arithmetic (Underachievement)
Spelling (Underachievement)
Confusion about instruction
Explosive or aggressive
Peer group relationship poor
Short attention span for age
Does not accept adult authority
Poor school/parent relationship
Withdrawn behavior
Anti-social behavior
Oppositional behavior

The referral-questionnaire was sent to the eight teachers of the elementary emotionally disturbed classes. The data from the returned referral-questionnaire forms

was analyzed and indicated that of the total 120 elementary emotionally disturbed children serviced by the Intermediate Unit in this county, 33 exhibited behavioral characteristics of severely disturbed children (Appendix B).

A triadic partnership combining the efforts of the therapist, teacher and parent is not a panacea. Psychiatric services can provide public schools with psychoneurological development information, psychosocial maturation, as well as providing monitoring and management of pharmacological interventions. While many state special education regulations do not mandate participation of physicians/psychiatrists or interdisciplinary treatment teams, the collaboration emerging from increased understanding is obviously beneficial (Eyde, DeSalvo, and Riley, 1983).

The effect of emotionally disturbed children on the regular classroom environment has been significantly ignored. The research reported has been conducted with other exceptionalities. Accordingly, only inferences can be made concerning the effects that emotionally disturbed children have on the regular classroom teacher (Vacc and Kirst, 1977).

Tyne and Flynn (1981) state that teachers should have more open-minded attitudes toward emotionally disturbed children and make an effort to understand them. It has been noted that the more training a teacher has in understanding the atypical child, the more effective the teacher is in reaching that child. Teachers in regular classrooms need to know how disturbed and disruptive children can be educated in the classroom.

Schools are required to involve parents in the planning and development of educational programs for severely handicapped students. Baker and Brightman's (1984) review of participation concluded that "most parents are far from fulfilling the role of providing information, helping with decisions, and serving as advocates. Pyecha (1979) found that only 49% of the parents contributed to the Individualized Education Plan (IEP) development and only 77% completed the simple task of approving the IEP. No survey has reported that all parents attend meetings, the proportion being about half or a little more (Scanlon, Arick, and Phelps, 1981).

Despite the concern of the past decade and the amount of resources expended there is an increased need for professionals to work together as an interdisciplinary

team to provide the functions and services to meet the needs of disturbed children. The need for more family interventions and group approaches is also apparent. Hopefully, long-range preventive actions are not going to be overlooked in the current trend for alternative programming.

Causative Analysis

Many people interested in the problem of childhood mental illness recognize that the younger patients are of low priority in the plans of some of the mental health centers and are being underserved.

Glasscote, Fishman and Sonis (1972) report that federal funds were made available to the states so that they might develop, over a two-year period, plans for organizing and providing comprehensive mental health services. Analysis of the plan disclosed that:

> nineteen of the proposals did not include services for children as a specialized area, only three mentioned public school mental health programs, and only thirteen discussed prevention of childhood mental illness as an integral part of general prevention.

The Joint Information Service Field Study (1974) described eleven of the community-based mental health services that had been developed. This study said:

> We do not believe any of these eleven centers could be said to come very close to meeting the needs of all the emotionally disturbed children within their catchment areas. Some of them provide hardly any service at all.

Another inherent problem in servicing emotionally disturbed children is that the services available have been, and continue to be fragmented. There are few communities in the United States which have all the facilities for comprehensive daytime care, education, and treatment of emotionally disturbed children.

The disparity of such programs reflects the feeling that such a service for children requires a special education program, which requires establishing a school, however small it might be. Such an arrangement is quite expensive, and many mental health personnel appear to feel that the responsibility of such a service properly lies with the school system.

Because many teachers and parents lack an adequate understanding of children, their problems, and their development, inappropriate referrals also present a problem. The Center's offer of service has resulted sometimes in wholesale numbers of referrals who are acting out students

and troublesome to the local school. The Center's subsequent efforts to educate the school about its proper role and function may sometimes result in that school's taking offense, or "writing off" the Center as a useful resource (Glasscote et al., 1972).

There is documentation of a growing number of professionals in the fields of education, community child mental health, and child psychiatry who seek to join forces on behalf of school children. Many pressing problems, conflicts and questions arise. The actual "how" as well as the "why" of psychoeducational teamwork between the mental health staff and the school staff has the potential of fostering the maximum development of each individual child (Lawrence, 1971).

Although psychoeducational teamwork has the potential for helping each child to reach his full potential, this approach also appears to have the potential for misuse if the best interests of children are not kept in mind. In attempts to cut costs, needed expertise could be eliminated from the process. In addition, it is conceivable that administrators or school boards might believe that teachers need less specialized training in order to serve these children since they are not "clearly" handicapped.

The comprehensive daytime therapeutic/education program should not be used to free schools and communities from providing a full range of services to young children, handicapped or not (Smith and Schakel, 1986).

The Related Literature

During the recent decades the very abundance of children and youth has created social problems, from crowded classrooms to crowded juvenile courtrooms. Today there is a need for a quickened community conscience responsive to the needs of all children, rich and poor alike. Thus, a child development theory for the future should have as one of its major goals the nurturance of caring (Richmond, 1983).

Identifying the Seriously Emotionally Disturbed Child

Health and happiness or a sense of self-worth must grow out of life as it is lived, not out of life as it is talked about in the context of a theory of personality. This brings into question the very nature of serious emotional disturbance in children. Rhodes (1982) suggests that emotional disturbance is not something in the person, not something a child has, not a neurosis or a behavior disorder, but rather that emotional disturbance is a symptom not of individual pathology but of a malfunctioning human ecosystem.

Classification can profoundly affect what happens to a child. It can open doors to services and experiences the child needs to become a person sure of his worth and appreciation of the worth of others. On the other hand,

classification, or inappropriate classification can blight the life of a child, diminishing his self-esteem (Hobbs, 1982). Existing identification and service programs for seriously emotionally disturbed children in the public schools are a reflection of several general trends: Growing national recognition of the problems of mental illness during childhood, greater pressure on school systems to assume a preventive and treatment role with regard to mental illness, and an increase in public sentiment that addresses the needs of persons with all types of handicaps (Long and McQueen, 1984).

Seriously emotionally disturbed children are a unique subpopulation of handicapped children. As a group, their deficits often are unclearly defined and not well understood by professionals in either health or education. Controversy continues with regard to questions of proper diagnosis and effective treatment. Confusion about how to distinguish "bad" or delinquent children from those with emotional disturbance has been common in school and community settings. Stigma has been associated with the diagnosis of "behaviorally disordered children," who form the bulk of mental health referrals, but who often appear to the public as more delinquent than ill. Uncertain knowledge and confused definitions has resulted in a public response to emotionally

disturbed children that varies from extremes of support and assurance to rejection and punishment. Some communities offer mental health counseling and family guidance in response to bizarre or inappropriate behavior by youth; others insist upon court and detention home approaches (Browne, Stotsky and Eichorn, 1977).

Failure to properly identify and appropriately serve a child with serious emotional disturbance has important consequences for the child, his family, and the community. The long-term results of untreated emotional disturbance can include family disruption, school failure, and destructive antisocial behavior. Equally as serious are the consequences of unnecessary or inappropriate determination of a child as emotionally disturbed. Such misclassification may deter a child's social and intellectual development and stigmatize him in his family and his community (Browne et al. (1977).

The Education for All Handicapped Children Act (P.L. 94-142) has established a clear mandate for school system services to emotionally disturbed children. However, the issue of stigma associated with labeling and serving a child as emotionally disturbed remains a serious concern. Greater efforts to educate not only the public, but particularly classroom teachers and administrators, about mental illness in children seems necessary.

While the issue of stigma remains prominent, it provides a convenient rationale for the failure of school systems and communities to serve emotionally disturbed children. In addition, a lack of appropriate information about the range and seriousness of childhood emotional disturbance prevents teachers from identifying many children who may need some form of special help (Long and McQueen, 1984).

The Seriously Emotionally Disturbed Child and P.L. 94-142

Educators and researchers within both regular and special education are examining the changes brought about by P.L. 94-142 and taking stock of where special education has come from and where it should be going.

Will (1984) cites several barriers to the implementation of the full intent and spirit of the law. Two of these barriers relate directly to overall models of service delivery: the barrier to integrate handicapped students in a heterogeneous society and the barrier between regular and special education. Will writes:

> It is evident that there are children who do not fit clearly into either the regular or special education delivery system. There is a sizeable group of children in the nation's schools today who are not being served adequately in the regular class environment, yet do not meet the federal or state requirements for being labeled "handicapped child."

Stainback and Stainback (1984) propose that special education and regular education be merged, arguing that there are not two types of students, regular and special, but rather that all students are individuals and differ along a continuum. They conclude that "a dual system of education can serve to foster exclusion of some students from regular education, reduce opportunity for equal participation by other students, and sanction other forms of discrimination."

Gerber (1984) in critiquing the Sixth Annual Report to Congress on the Implementation of P.L. 94-142, urges a redirection of energies and resources to general education programs and their attempts to respond more appropriately to the needs of students who are difficult to teach or manage and to do so without their removal from educational context.

In reviewing P. L. 94-142, the Heritage Foundation report (May 11, 1984) states that the requirements of the law have actually reduced the effectiveness of the education received by handicapped children by putting them in regular classrooms where they are without individualized programs and are tormented and teased by other children. The Heritage Foundation report proposes that special schools be established to meet

the special needs of students "who cannot easily be incorporated into a normal school program."

Involving parents in the educational program of their child is generally thought to produce positive benefits (Turnbull, 1983; Wiegerink, Hocutt, Posante-Loro, and Bristol, 1980). Belief in these benefits has been associated with legislative mandates requiring programs to include parental involvement components. For example, one of the six major principles of P.L. 94-142 deals with parent participation and states that parents must be included as members of the committee charged with developing their child's individualized education program. In addition, they are encouraged to participate in public hearings, serve on advisory panels, and belong to advocacy groups.

VanDenBert and Donner (1986) present the Kansas efforts to make community-based services for seriously disturbed children a reality. The Kansas efforts are funded by the National Institute of Mental Health under the Child and Adolescent Service System Program (CASSP). The initiative is designed to ensure that a focus on services for children and adolescents with severe emotional problems exists in state mental health authorities, and to encourage states to develop continuums of community-based

services for this population. Through CASSP, states are encouraged to involve parents in developing service systems for this population. In Kansas,the Office of Child and Adolescent Mental Health Services contracted with the School of Social Welfare at the University of Kansas to develop a comprehensive effort to reach parents. The Family Input Program provides a forum for parents of children with serious emotional problems to meet together in a supportive way and decide what actions they might take in advocating for their children. Based on the positive results of the pilot project, Family Input meetings are now being organized in five other communities across the state.

During the 1960's, the burning issues in special education for emotionally disturbed children were conceptual models. The primary issues today involve parent/family involvement, the merger of special and regular education, and whether to teach the seriously disturbed child within the school setting or to establish special schools to meet the needs of these students.

Future implications lie in prevention due to the important change to the Education for All Handicapped Children's Act (P.L. 94-142) which Congress reauthorized as P.L. 99-457 in October 1986. The new amendments expand the

program by increasing grants to states for handicapped education services to disabled three to five-year olds and assist states in developing early intervention services for handicapped infants and toddlers from birth through age two.

Alternative Programs and the Seriously Emotionally Disturbed Child

Over the past ten years a growing number of school districts across the country have established special programs designated as "alternative." Explanation for the emergence of alternatives within public school systems are widely divergent (Arnove and Strout, 1980). The alternatives have been characterized as impressions of a new responsiveness to the diversity of American Society; as stop gap measures to preserve a faltering system of public education; as devices to meet the needs of individual students; and as means to minimize or avoid conflict over pressing social issues (Arnove and Strout, 1980).

Positive Features of Alternative Programs

Advocates of alternatives for disruptive students point out that they provide a supportive learning environment where such youths can gain basic academic and social skills, experience success and social approval, participate in important decision making and feel good about themselves. Features of alternative programs aimed at achieving these ends include small, intimate schools with a low student adult ratio, individualized instruction, competent and caring teachers, specialized personnel to provide counseling and social services (Arnove and Strout, 1980).

Conditions conducive to warm interpersonal relations, student success, and enhancement of self-concept are:

Size: Small scale schools with low student-adult ratios provide the necessary conditions for more intimate interactions between teachers and learners. They are more conducive to a sense of community. Berger (1979) reports that the sheer size of urban schools is a cause of violence and there is an "almost" total lack of violence in alternative schools."

Teachers: The teachers in alternative programs are recruited, in many cases, because of their interest in working with the kind of student who is defined as disruptive or troublesome. Frequently such teachers are described as "more flexible," as being student centered, and capable of individualizing and personalizing teaching.

Student: For many students in alternative programs, conventional schooling has been a brutilizing experience characterized by continued failure. Through a variety of forms of instruction and evaluation it is possible to structure educational environments so that virtually all students can experience success (Arnove and Strout, 1980).

Cohen and Filipczak (1977) in their study of the CASE project at the National Training School for Boys point out that the work completed by the participants clearly demonstrates that not the youngster but the public school system and its ecology has failed. Although the CASE project pertains to an extreme population (forty-one incarcerated teenagers) Cohen and Filipczak believe that the principles and procedures used in the experiment have generalizability and possible application to education systems.

In a review undertaken at Indiana University of over fifty alternative school evaluations, from every part of the country and representing a range of different types of alternative schools, Barr(1979) reports a recurring pattern emerged. Students experienced significant and often dramatic changes in the affective area. Among the most salient findings were:

- The self-concept of alternative school students appears to improve.
- Students tend to have better attitudes about school.
- More positive attitudes tend to be demonstrated in higher attendance rates, lower disruptive behavior and less violence.

Negative Features of Alternative Programs

Despite the potential of alternative programs to assist students who otherwise would be written off as failures by school and society, there are limits to the effectiveness of such programs. Arnove and Strout (1980) cite the following limiting factors:

- Labeling youth "delinquent, neglected, abused, incorrigible," reinforces the development of lower self-concept.
- In many school districts alternatives are now equated with school suspension. As a higher percentage of minority students are excluded from schools, these alternatives, in effect, may lead to isolation for black, latino, native American, and poor white students.
- There are strong indications that "dumping" is occurring through the use of alternative programs. This is the process by which teachers, administrators, and counselors get rid of the troublemakers by "referring" them to alternative programs.

- In alternative programs, variations of Skinnerian operant conditioning are often used. Token economies are established where students accumulate points for walking into a classroom, sitting down, completing their tasks, and not disturbing others. One teacher in such a program queried how individuals could survive in such an atmosphere that stifled creativity. In the hands of understanding and caring teachers, the token system might help individuals not reached by other methods. Too often, operant conditioning is neither adequately understood nor ethically utilized. Students themselves manipulate the token economy system to their advantage to avoid academic work or to escape boring classrooms and to strike back at the controllers.

- Finally, too often, too little is done too late. To effect changes in aggressive behavior, attitudes and personality patterns, the researchers suggest that intervention programs might have to occur as early as the first three grades of elementary school.

Alternative programs for children and youth are frequently the stepchildren of school districts, dependent for their survival on the outside benefactor, such as the federal government or philanthropic foundations.

To date, the prospects of widescale establishment of options in public schooling are not encouraging. Change is more likely to be at the level of individual alternative programs in which staff, students, and parents feel a sense of community and attempt to jointly give substance to a more effective learning environment (Arnove and Strout, 1980).

Educational/Therapeutic Approaches to Program Development for the Seriously Emotionally Disturbed Child

There is increasing interest in identifying groups of children at risk. The behavior problem child is at risk for academic learning and for the development of appropriate social skills. The number of such students appears to be increasing, posing ever greater demands on the resources of the public schools. The current economic climate and the pressures for cut-backs in services will bring costly out-of-school placements under even closer scrutiny. Thus, school systems will be faced with the increasing need to reach out to these difficult to reach students in nontraditional ways, seeking more flexible and more creative ways to meet their needs (Erikson, 1978).

The Quincy, Massachusetts,Public School System developed a program to identify and address the psycho-educational needs of high risk, difficult to serve students. Anderson and Limoncelli (1982) report on a study focusing on the highest risk students currently attending the target school, with the goal of identifying specific characteristics of the students and their families in order to develop resources within the school system and the community to better address their educational and emotional needs. From the data collected, the following profile emerged: The high risk, difficult to reach student is a likeable child

with average intelligence and good verbal communication skills who is responsive to some adults and can relate reasonably well on a one-to-one basis, especially if this relationship is established outside the classroom. The student does not perceive the problem in the same way as does the school. Where the school sees the child's behavior as a problem, the children see the school with its rules and regulations as the problem. They have a negative attitude toward school. As they get older the negative attitude is expressed through acting out behavior. By the time these students reach sixth grade they are beginning to feel hopeless about the school situation. In peer relationships trust is expressed more in their peer group (or gang) than adults. More outlets throughout the school day for tension release or impulse drainage are required for these students than for regular students. They disrespect authority, are street wise and usually unsupervised in the community.

From the data collected the following family profile for the high risk, difficult to reach child was drawn: This is most often a single parent family. Their orientation toward life is based on survival and they tend to move from crisis to crises (Cohen, 1980). They are generally intimidated by or unaware of existing and available

community supports and resources, and usually seek help on an emergency basis. In general, these single parents reflect a sense of disorganization and hopelessness that is also reflected by their children.

Fourteen months after this project was conceived an Outreach Program for elementary students and a crisis room staffed full-time by a crisis teacher experienced in working with behavior disordered children was established. In addition, the possibility of introducing an industrial arts program staffed by senior citizens is being explored.

Programs such as this are much less costly and potentially more effective than expensive out-of-school placements (Anderson and Limoncelli, 1982).

The Bellefaire day treatment program is an integral part of the service offered to children by the Bellefaire Residential Treatment and Child Care Center and its sister agency, the Jewish Children's Bureau of Cleveland. Their services to children include residential treatment, day care, foster care, group homes and day treatment. The day treatment program, in operation since September 1970, currently serves 14 children aged 7 to 16. The goal is not merely to return the child to public school but to help him develop more appropriate motivations and strengths

in social skills, motor skills, awareness of feelings of self and others. The program operates Monday through Friday from 8 a.m. to 5 p.m., two evenings a week until 8 o'clock and on Saturday morning from 9 until noon. Since the program emphasizes the child's total development and treatments, it was thought important to extend it beyond the normal school day and keep it in operation during most school vacations.

Ross and Schreiber (1975) report the major ingredients of the program are group work, special education and psychotherapy. The value of day treatment lies in the planned integration of these services. Diagnostically, most students in this program can be classified in three major categories:

1. The behavior-disordered child, i.e., hyperactivity, temper outbursts, rebellious, lying, and sexual acting out.
2. The neurotic child, i.e., anxieties and fears about school and/or family members, overconscientiousness, inhibited behavior resulting in restricted schoolwork and play.

3. The immature personality pattern, i.e., childish speech, clinging, easily picked on and dependent relationships with parents and friends, and excessive difficulty in separating.

Parents attend parent-group meetings every other week and meet weekly with a parent worker. In some situations, conjoint family therapy is the treatment of choice. Goals of work with the parents are 1) obtaining information on a regular basis about the child's life at the day center and 2) increasing their understanding of their child's feelings and helping them find a healthier way of relating to him.

After over three years of operation, Ross and Schreiber (1975) list the following positive and negative findings of the day treatment program:

- Parents have experienced visible changes in themselves and their children and there is strong parental support of the program.
- The technique of behavior modification can complement analytically oriented insight psychotherapy.

- Providing an abundance of recreational activity motivates the children to attend program regularly.
- Most children cease seeing their friends in the community because of the stigma they feel attending a treatment institution.
- Closing the program for the month of August appears to have a positive effect on the children and the parents. With a few "borderline" children, however, the month away sometimes has a deleterious impact, and special arrangements have sometimes been made in these instances.
- Programs such as this day treatment center are too costly for children of lower socio-economic status. Subsidies, public or private, are needed to make such a program a reality for disadvantaged children.

Of the 35 children in the program during the last 3 years, 14 remain in the program and 21 have been discharged. Of the 21 discharged five were referred to residential treatment centers, 13 were treated successfully, and three were removed from the program by their families within the first month of their involvement.

The Woodward Day School (WDS), has been in operation in Worcester, Massachusetts, since 1970. It is a co-operative effort of the Worcester Public Schools, the Worcester Youth Guidance Center, and the Worcester State Hospital who have attempted to bridge two traditional distinct fields, i.e., education and mental health.

The WDS was developed 6 years ago to provide a supportive educational environment for aggressive adolescents ages 13-19 whose behavior problems made them unable to function within the public schools. Unique in this program is the concept that if the goal is to reintegrate a student into the public school system, emphasis is placed on academic classes. If integration does not appear feasible, emphasis is on vocational aspects. When a student is readmitted to a regular school, the WDS staff continues to provide support. The staff also maintains contact with the families of students and provides assistance in crises. This program follows the public school calendar, but in addition remains open during school holidays.

This type of alternative day school program has significant implications for both treatment and prevention (Kennedy et al., 1976).

The Youth in Psychoeducational Services (YIPS) Public Schools of the District of Columbus, has as its purpose a specialized program for seriously emotionally disturbed children who might otherwise be institutionalized (Guines, 1981).

The target population consists of students who have psychiatrically diagnosed psychotic, prepsychotic, or borderline psychotic disorders (severe emotional disorders with behavioral deficits in thought processes, affect, and perception).From this population 17 students, age 13 to 18, participated in the program during the 1980-81 school year.

The staff consists of four special education classroom teachers, four educational aides, a speech/language therapist, a clinical psychologist, and a psychiatric social worker. Ancillary services are provided by an art therapist, an adaptive physical education teacher, and a counselor. Medical screening is provided by a part-time doctor and nurse. The principal of the school serves as project director. Funding under this program pays for one teacher, a psychiatric social worker, and two of the aides.

The identification and diagnostic processes include four main areas: 1) basic descriptive data: 2) educational; 3) sociopsychological, psychiatric and medical, and 4) input from parents.

Based on the diagnostic information, an appropriate behavioral, academic, speech and therapeutic program is developed for each student and implemented through the Individualized Education Plan (IEP).

The classroom management process emphasized teacher structuring of expected behaviors in both group and individual situations. For example, assigning clearly defined tasks; rechanneling energies into acceptable activities; limiting space and tools to reduce stimulation; comforting; and, as a last resort, using physical control such as restraining when a student becomes a danger to himself or to others.

The academic process is characterized by individual and small group instruction using a multisensory approach. Teachers try to assure success experiences through the use of immediate reinforcement and motivating materials. Special training designed to decrease perceptual deficits is incorporated into the classroom program. Therapists in speech, art, adaptive and regular physical education, and counseling also contribute to the academic core.

The therapeutic component is considered an integral part of the psychoeducational program. Students are involved in at least nine therapy hours per week including three hours in individual therapy, two hours of group therapy,

and four hours in a therapeutic community. During the therapeutic community sessions, students and staff discuss positive and negative aspects of the program.

All staff members have previous experience and training in working with disturbed youngsters. Problems and possible solutions are discussed at weekly staffings attended by all YIPS faculty members. A needs assessment was done in September 1979 to aid in planning for the 1979-80 school year and another in June 1980 for the next school year. At monthly staff development sessions, training has been offered in the areas of classroom management, behavioral techniques, and development of a treatment plan.

Parents are involved in the diagnostic and placement procedures and are offered the opportunity to receive counseling on a regularly scheduled basis or as an emergency arises. They are invited to attend therapeutic team meetings and receive written summaries of such major changes in a student's program or placement as contemplated. In accordance with P.L. 94-142 parents were involved in the development of their children's Individualized Education Program (I.E.P.).

This project was first implemented during the 1978-79 school year and was followed by a summer program. The final evaluation demonstrated its cost effectiveness. In its second year of operation YIPS continued to provide instructional and support services to this identified group.

Williams (1982) describes the Cavendish program, London, England, which has a striking rate of more than 50 percent of emotionally disturbed children returning to classrooms in regular schools. While the reasons for its success are many, the author emphasizes those which have practical application for classrooms and special education programs in American schools.

Cavendish parallels the American primary school in age group, setting, and grounds. What makes it different from an American school is that it is organized to be, and operates as, a special education institution designed to serve severely disturbed children 7-12 years of age. Its physical plant contains six classrooms, three offices and a cafeteria/gym. The building is located on fenced grounds adjacent to a junior high. The number of students enrolled is thirty-two with more boys than girls. After failing to cope with the general education system they have been referred for one, or all, of the following: 1) aggressive or violent acts; 2) disobedience or flaunting authority; 3) vandalizing property; 4) inability to concentrate or complete work; and 5) expulsion from school.

Cavendish has a full complement of trained specialists:

- One headmistress who is a specialist in training maladjusted students.
- Four special education teachers.
- Each teacher is also a specialist in one of the skills needed to staff a room (science, woodship, etc.).

Among other specialists are a recreation therapist and physical education teacher trained in social development through play, games, and sports; an art therapist; six teacher's aides; two half-time social workers, who spend most of their time in parent contact and home counseling; a psychiatric consultant, a part-time speech therapist; a maintenance worker and a cook. The full complement of specialists allows staff to support each other in the event of crisis, and to supply consistency of instruction and help. An important feature of the program is immediate, follow-up home visits to resolve crises that have arisen at school.

The daily schedule at Cavendish offers only two half-hour academic periods, one in the morning, one in the afternoon. The remainder of the day is taken up with various activities, such as play, recess and lunch. Rooms vary in the degree of structuring. The least structured is the

science, electronics, and animal room. The general play room is more structured, and the woodshop even more so. The most structured of all is the classroom, which includes a cooking center. Though students are grouped by age 7,8,9 year olds, or 10,11,12 year olds, they are free to try something more structured or are free to return to the science room.

The school operates with great flexibility, not only in movement between classes, but in choices offered to students during activity periods. For instance, at 11:30 special events are available ranging from gardening, or arts to ping-pong and continued work on individual projects. A focal point of the day is the daily meeting at 10:30 attended by all the school. Here good behavior is praised. The meetings are not used to discuss bad behavior, unless it is necessary to solve some problem affecting the whole school. All the school rules are made at the meetings, jointly by staff and children. Another event which supports the daily meeting is the "Court," which has the head of the school acting as clerk to the Court, and four student justices who are elected termly at the school meeting. Complaints are made either at the suggestion of a staff member or by a victim of a bully. Not only is the Court a deterrant to aggression, it provides social training by presenting both sides of an issue and reaching a resolution by discussion.

Return to regular school is marked by encouragement to assume responsibility. A student first tries mornings at the adjacent regular school. The student makes the decision about how many hours he will remain into the afternoon. A student can spend months or a year in this transition period, but the move back to regular classrooms is his own decision and is the result of the Cavendish program's emphasis on student's acceptance of responsibility for personal choices.

Perhaps the thing that most separates Cavendish from American teaching practices is the considerable time devoted to physical activity, sports, soccer, games, the whole range of physical play. While it is unlikely that schools in the United States who serve special education children will receive support for professional staff and follow-up in the home to the extent enjoyed at Cavendish, the use of supervised and unsupervised play is well within the scope of current tight budgeting in American schools.

For children to whom violence is the main form of expression, little academic training can go on until they learn there are other modes of behavior more fulfilling than hitting or kicking. The use of play, games and sports can be valuable experiences in the art of living and learning with others.

Summary

Throughout the 20th century three segments of the social welfare system have been involved in the care of aggressive, acting-out emotionally disturbed students: education, mental health, and juvenile correction systems. Kennedy et al. (1976) find that none of these three systems has had outstanding success in treating these students. The school system has few teachers with the training necessary to communicate with these children (Levine, Scotch, and Vlasek, 1979). Traditional psychotherapy, whether on an outpatient or inpatient basis, has little effect on their behavior. Mental health professionals often diagnose these students as sociopathic and abandon all hope for them (Lewis and Balla, 1976). The correctional institutions appear to reinforce delinquent behavior rather than extinguish it (Kennedy et al., 1976).

The problem of providing for emotionally disturbed children is a critical one requiring bold measures. Society will not continue to tolerate the assignment of disturbed children to detention homes, to hospitals for adults, or to institutions for the mentally deficient. The social need for imaginative planning is acute (Hobbs, 1982).

In an attempt to break out of the circle of failure, many school systems are experimenting with so-called "alternative programs," either in traditional school settings or in noneducational locations. Substantial differences exist among school districts in the definition and scope of alternatives. A school system might provide a few alternatives, many, or a comprehensive range of options. There are approaches aimed at the total school-age population of a district, and there are approaches designed to serve only special subgroups within that population (Arnove and Strout, 1980).

Those in the forefront of the alternative education movement advocate a system of public school options which would provide a choice among distinctive learning environments to all students (Smith, Barr, and Burke, 1976). In practice, however, alternatives most frequently serve two types of students, those who are intellectually gifted or artistically talented, and those whose school experiences are characterized by failure. The concern here is the subset of alternatives designed for students who do not succeed in conventional schools and who are disruptive.

Programs for disruptive children presently comprise about one-third of the alternative programs in the United States. These alternatives vary from part-time programs serving a few students within an existing school to separate

schools serving several hundred students. There are also cases of alternative programs existing in nontraditional locations, such as community health centers (Arnove and Strout, 1980).

Implications of alternative schools for seriously emotionally disturbed children is influenced by social, political and economic factors, coupled with the unique conditions of local school districts. Browne et al., 1977, emphasize the detection and subsequent treatment of seriously emotionally disturbed children is an issue which needs further and more detailed examination. Legislative actions and financial expenditures on both federal and state levels, as well as attention to the problem in the public press and media, illustrates a growing public awareness of childhood mental illness and its long range effects.

Federal legislation and funding, which culminates in the Education for All Handicapped Children Act of 1975 (P.L. 94-142), has played an increasingly important role in determining how local public school systems will function in regard to all handicapped children, and emotionally disturbed children specifically. School system officials emphasize that approaches to services for ED children, including family counseling and child psychotherapy, are usually considered necessary to really help ED children, however, officials stated that they have no power to compel other health or

social service agencies to work cooperatively with them in assisting such children. In approximately one-third of the school districts, good cooperative working relationships had been developed with health and social service agencies, but the other officials stated that school systems were expected to bear the major burden of helping ED children without needed supplementary help (Long and McQueen, 1984).

Implications for educators and psychotherapists regarding alternative programs evolves around the "given" that the major ingredients of the program are education and psychotherapy. Each ingredient has its own identity but the value of the alternative program lies in the planned integration of education and mental health.

Enabling students to gain full control over their academic performance is an important goal, particularly for those students with severe behavior disorders (Davis, Uhler and Kelly, 1985). To deal with such behaviors, the ED teacher individualizes instruction generally through the use of programmed instruction, learning contracts, and point systems or token economies which reward students for desirable classroom behaviors and progress toward specific academic goals (Kennedy et al., 1976). This behaviorist approach is used by teachers of ED children because of the need for immediate and viable intervention techniques. They cannot afford to wait until the therapist places the child

in individual psychotherapy where a child's long repressed early memories would be analyzed. Rather, these frontline workers need techniques that work in the here and now (Hobbs, 1982). These practitioners have for a number of years been confronted by two fundamentally opposed views of disordered behavior. 1) The classic psychodynamic position held that disturbed behavior was only a symptom and that the real problem was an underlying personality conflict that had to be solved. 2) The classic behaviorist view was that behavior itself was the problem, and changing the behavior eliminated the problem (Redl and Wineman, 1952). Redl's classic writings are as relevant today as when they were first penned and seem to acknowledge the value in each of these seemingly polarized views (Brendtro et al., 1980). Redl challenged his colleagues with the argument that "surface behavior" was itself worthy of observation and manipulation and that many problems would yield to influence at the behavioral level without employing complex psychotherapeutic procedures. On the other hand, he did not routinely ignore the perceptual and affective processes; his classical research showed clearly that the child's inner life often served to elicit or perpetuate problem behavior. Thus, he believed that it was necessary to make informed judgment about whether a given problem could best be handled at the level of behavior or at the level of emotions. This required a differential diagnosis, that is, an assessment of the child

and his life space in order to understand the meaning and significance of the behavior. The technique of behavior modification can complement that of analytically oriented insight psychotherapy. Some practitioners might find such a melding more difficult if they believed the two theories were in serious conflict. In Redl's philosophy lies the key to linking education and psychotherapy for the seriously emotionally disturbed child.

Implications for parent/family involvement in alternative programs indicates a strong correlation with parent involvement and student performance. Believing that there is little that school personnel and policy makers can do to alter the formal education, occupation, income, presence or absence of a parent, or the learning materials found within the home, researchers have recently begun to turn their attention to more alterable factors, i.e., what parents do in their interaction with children that might augment school achievement (Bloom, 1984). What might be called "the curriculum at home," predicts academic learning twice as well as socioeconomic status of families. These programs can be implemented at low cost. The process involves sending a note or a call to parents who then initiate some prearranged contingency depending on the behavior the teacher seeks to change. Most of this research has focused on modifying disruptive student behavior in school.

There is reason to believe that alternative programs involving parents directly in the education of their children, especially when these are reinforced by comparable school-based efforts, have long term effects on student performance in school (Hobbs, 1978).

Arnove and Strout's (1980) research shows the only suggestion to emerge logically from the findings is that state and local education/mental health agencies should be granted monies for individual programs so that they can plan and implement innovative alternative programs for the seriously emotionally disturbed child.

Chapter III

STATEMENT OF GENERAL GOALS

The positive effects that can be accrued from alternative programs, if evaluated earlier, most likely would not have yielded a sound picture of what innovative and stable programs can provide for seriously disturbed children. Those evaluations are timely now. The value of the preceding years rests in the lessons learned about the problems and successes that occur in widescale program planning and development, including the attitude that must change about children for community-based programs to succeed; the range of services that must exist and be coordinated for children to be served well in communities; and the importance of broadly defined case management as the cohesive element in a system of service (Behar, 1986). Case management functions ensure that treatment strategies are designed to enable the child to achieve treatment goals; that treatment goals and processes are modified when and if necessary to realistically address the child's capability and need; and that a regular review is conducted to guarantee that treatment time is of the shortest period necessary (Ray, 1985).

Prehm and McDonald (1979) found that efforts to meet educational needs of the seriously emotionally disturbed child will have to focus on the delivery of special

education in a wide variety of settings and focus on younger age groups outside those being presently served in school programs.

The general goal of this practicum was to provide a comprehensive school-based therapeutic/educational program for severely emotionally disturbed children, ages 8 to 13.

Behavioral Expectations

Behavioral expectations were as follows:

1. Twelve of the 15 student participants in the therapeutic/educational program will increase social skills by 90% as measured by the student sociometric rating.

2. Twelve of the 15 student participants in the therapeutic/educational program will decrease behavioral disorders by 90% as measured by the Level of Functioning (LOF) goal attainment scale.

3. Twelve of the 15 student participants in the therapeutic/educational program will improve academic performance by one grade level as measured by standardized educational tests.

Evaluation Instruments

The following five evaluation instruments were utilized to evaluate performance objectives.

1. A writer-devised pre and post student sociometric rating to measure increase/decrease in social skills (Appendix C).

Peer sociometric instruments present an objective questionnaire requiring a response for each classmate on a Likert-point scale. Measurement rests on stated perceptions of peers. Peer sociometric instruments have also been used in mental health programs to target at-risk populations. Sociometric techniques provide information on students' interpersonal attraction and social distance, and data from peer ratings have been found to be the best predictor of later socioemotional adjustment (Rolf, 1976).

2. A therapist-devised treatment plan/review measured by a Level of Functioning goal attainment scale was utilized to measure increase/maintain/decrease in behavioral problems (Appendix D).

Baseline data was gathered on each child at intake to be compared with data obtained at specific program intervals. Functional assessment is one response to the growing need for

objective measures of outcome in psychological/psychiatric treatment. The Level of Functioning (LOF) Scale consists of six subscales: Self, Peers, Family, Adult Authority, Task Performance, Social/Emotional Functioning. Each subscale is composed of functioning "indicators" which are descriptively developed implying degree of functioning (Carroll and Williams, 1982).

3. Standardized educational tests were utilized to measure academic performance.

The Woodcock Reading Mastery Test

This test was used to measure: Letter Identification, Word Identification, Word Attack, Word Comprehension, and Passage Comprehension. Split-half and test-retest reliabilities range from .02 to .99 for the five subtests. No information on concurrent validity is provided in the manual.

The Key Math Diagnostic Arithmetic Test

This test was used to measure: Mathematical Skills in Content, Operations, and Applications. The reliability of the Key Math total score is satisfactory, as noted by a median split-half reliability coefficient of .96. Validity information available about the Key Math is limited. The Key Math Test provides useful information

that can guide teachers in their selection of appropriate procedures for remediation of arithmetic problems. The test appears to be a useful addition to the clinician's assessment battery for working with exceptional children.

The Wide Range Achievement Test (WRAT)

This test was used to measure: Writing and Spelling skills. Split-half reliability reported in the manual are excellent, ranging from .94 to .98. Validity correlations between the WRAT and equivalent tests are in the vicinity of .60 with various group children, including the emotionally disturbed. The WRAT is popular because it is quick and easy to administer, provides standard scores, and measures both writing and spelling ability.

Chapter IV

SOLUTION STRATEGY

Discussion and Evaluation of Solutions

Mental health work with schoolchildren is almost 100 years old (Berkovitz, 1985). However, psychopathology such as anxiety, depression, and neurosis were handled in out-patient clinics, off the school premises and outside school control. Even such school-harming conditions as hyperactivity or school phobia were treated elsewhere, and not by educators (London, 1987).

Prior to the legal mandate of Public Law 94-142 (1975) to provide appropriate education for handicapped children, the strategy used and recommended most frequently by school systems to treat seriously emotionally disturbed children was to provide a socially/emotionally disturbed (SED) classroom within the school setting with therapy at the local mental health site.

This plan was utilized in this county until 1982 when a Partial Hospitalization for Adolescent Services and Education (PHASE) program for SED students ages 14 to 18 was authorized by the Mental Health Center, in affiliation with the County Mental Health/Mental Retardation program, and fully serviced by the Intermediate Unit's Socially/Emotionally Maladjusted Division. Twenty-four students are enrolled and the staff consists of a director, two teachers, four therapists and a secretary. Students are referred from public schools, the

community mental health center, the intermediate unit and local service agencies.

This attempt to span the mental health and education systems is designed to exclude the conduct disordered adolescent that is problematic for both systems to a setting removed from the school site.

A program for learning disabled and emotionally disturbed students ages 13 to 21 initiated in a large urban school district in Wisconsin provides an academic/therapeutic program designed for students whose past achievement and school adjustment have indicated the need for a small, closely-supervised environment with intensive treatment services. Students are referred to this alternative middle/high school, which services 85 students, from other public schools, day and residential treatment facilities, and the children's court system. The staff includes a self-contained classroom teacher and a paraprofessional per class, four psychologists and five therapists. The principal serves as the director.

This model excludes students from a regular school setting to a closely-supervised special school (Kafka, Chiovoloni, Kimmel, Tackes and Uhler, 1984).

Tureff and Flieger (1987) report on a psychotherapeutic day school in New York designed to treat children and adolescents with serious behavior disorders. Enrolled in the school are 70 elementary, intermediate, and high school students who present a variety of diagnostic disorders including childhood schizophrenia, learning disability, adjustment disorders (including depression and conduct disorders) and school phobia. The school has ten elementary and secondary classes with a maximum of eight students per class. The staff consists of a special education teacher and one assistant per class, two full-time social workers, a consulting psychiatrist, and four psychologists. A guidance counselor, a psychiatric nurse, and a crisis intervention teacher are also a part of the treatment team. Each student receives individual therapy at least once a week and every parent is involved in some form of regular counseling. With intensive multidisciplinary services, i.e., special education, individual therapy, and family counseling, the students significantly improved academically, behaviorally, and functionally within the family system.

This model combines both mental health and special education services. The ultimate goal is to prepare students for mainstreaming into the regular school system.

A review of the literature on psychotherapeutic day schools (Baenen, Stephens, and Glenwick, 1986) suggests

that in spite of a scarcity of research studies on the outcomes from such programs, the majority of day school programs report a high percentage of positive results with their students.

Almond (1975) contends that young children should not be treated in the same setting as are adolescents. Strauss, Downey, and Ware (1980) reviewed the relevant literature and discussed the issues involved with numerous colleagues. The literature was surprisingly mute on this topic. They speculate that this absence of reports may have arisen partly from the tradition of separating adolescent and child mentally ill inpatients, a practice that began in the United States about 10 years ago and has been followed almost universally since. The responses of colleagues was invariably one of disapproval in placing younger children in the same setting as adolescents. Perhaps this was a result of historical accounts of abuses, concerns that the older children might bully or hurt the younger ones, or would provide bad models.

From the limited information available, it appears that integrated programs might be valuable but it might be wise to start with partial integration of age groups.

Description of Selected Solution

Because of the prime concern at this local community mental health center to provide services to children with serious emotional disturbances, a combination of efforts were utilized to bring a comprehensive school-based therapeutic/educational program (STEP) for severely emotionally disturbed children ages 8 to 13 into being by September 1, 1987.

For a number of years practitioners have been confronted by two fundamentally opposed views of disordered behavior. 1) The classic psychodynamic position held that disturbed behavior was only a symptom and that the real problem was an underlying personality conflict that had to be solved. 2) The classic behaviorist view was that behavior itself was the problem, and changing the behavior eliminated the problem (Redl and Wineman, 1952). Some practitioners might find such a melding more difficult if they believed the two theories were in serious conflict.

As this practicum progressed the teacher and therapists, integrated behaviorist and psychoanalytical philosophies and theories.

Involving parents in the educational program of their children is generally thought to produce positive benefits (Turnbull, 1983; Siegerink, Hocutt, Posante-Loro, and Bristol, 1980). Belief in these benefits has been associated with legislative mandates requiring programs to include parental involvement components. For example, one of the six major

principles of P.L. 94-142 deals with parent participation and states that parents must be included as members of the committee charged with developing their child's individualized education plan. In addition, they are encouraged to participate in public hearings, serve on advisory panels and belong to advocacy groups.

According to a study by Johnson, Chandler, Kerns, and Fowler (1986) family involvement in the educational program of their children is gaining increasing interest in areas of special education and early intervention. Families can make significant contributions toward their child's education. Because family characteristics may vary from community to community, educators must learn from the families they serve what parents are saying about family involvement in school programs.

To involve parents as advocates for their seriously emotionally disturbed children, a therapist home/school visitation program was initiated as a component of this practicum. Also, a direct link was made with the Children and Adolescent Services System Program (CASSP) and the Homebuilders Outreach Program for Emotionally Disturbed Children and their families (HOPE).

The Education for All Handicapped Children Act, P.L. 94-142 has established a clear mandate for school system services to emotionally disturbed children. However, the issue of stigma associated with labeling and serving a child as emotionally disturbed remains a serious concern. Greater efforts to educate not only the public, but particularly classroom teachers and school administrators, about mental

illness in children is apparently necessary (Long and McQueen,1984).

A study by Gans (1987) was undertaken to investigate the importance of both demographic and attitudinal variables which may be important to determine whether or not there was any discrepancies between regular and special education teacher group profiles associated with the development of a teacher's willingness to work with handicapped students. The results of this study contain several points which could have an impact upon inservice and preservice effectiveness.

First, the special educator was affected more by support services and variables pertaining to the educational and affective aspects of the learning process. Second, classroom teachers continue to express dissatisfaction with their current level of expertise which may represent a perpetual concern rather than one which will decrease with intervention. A third finding, the strongest predictor of both the regular and special educator's willingness to educate students with disabilities, was in the number of different disabilities he or she was willing to approach, not how strongly the teacher felt about teaching handicapped students. The handicaps creating the most concern differed for the two teacher groups.

Emphasis upon the instructional aspects of the program rather than personal characteristics of the teacher is more apt to lead to increased communication and trust between special educator and regular educator teams. Methods which provide for frequent and routine communication can be used to clarify the perceptions and expectations of the regular and special educators involved

(Sparks, Nowakowski, Hall, Alec, and Imrich, 1985).

In a study by Payne and Murray (1974) inservice teacher training was ranked as the number one need of regular teachers who are asked to meet the needs of emotionally disturbed children. Regular teacher education that stresses adequate support personnel and positive experiences with emotionally disturbed children is essential to inservice programs. Having classroom teachers work with experienced special education teachers appears to be one way of effective mainstreaming.

A study by Campbell, Dobson, and Bost (1985) revealed that the behavior problems of students in mainstreamed classrooms may be due in part to the expectations of educators who have not internalized information on teaching the diversity of students found in that setting. The educators involved in this study were primarily regular classroom teachers but also included counselors, librarians, special educators, and administrators. They appeared to perceive student behavior problems as more serious when displayed by nonhandicapped students than when displayed by mentally handicapped students. The same educators recommended more behavioral treatments having an authoritarian orientation for nonhandicapped than for handicapped students. This study indicates educators need to develop attitudes and skills necessary for behavior management in the mainstreamed school environment.

An intricate part of this practicum was to educate classroom teachers, school administrators, and the general public about mental illness in children and the stigma associated with labeling and serving emotionally disturbed children.

Report of Action Taken

This practicum addressed a major service gap and critical unmet need in this county by establishing a school-based therapeutic/educational program (STEP) for seriously emotionally disturbed children 8 to 13 years of age. The aforementioned solution techniques were incorporated into the program with emphasis upon community relations.

A steering committee was formed to explore the joint concern of the mental health center and the intermediate educational unit in developing and expanding services for the target population. This committee included representatives from the mental health center and the intermediate educational unit as well as the Executive Directors of both service agencies. The writer was named program director to be responsible for the tasks associated with program planning.

The mental health center's representatives visited existing alternative program sites for the purpose of compiling data through observation and interviews with program personnel.

The mental health center initiated a Rates-Under-Treatment (RUT) assessment of latency aged, emotionally disturbed, clients who were diagnosed as severely disturbed. The data for this assessment was gathered from the Center's medical records and revealed 36 severely disturbed latency aged children in need of intensive treatment (Appendix A).

The intermediate unit initiated a Referral-Questionnaire (R-Q) assessment which was circulated to their Socially/ Emotionally Disturbed classroom teachers. The data for this assessment was gathered from the returned R-Q forms and revealed there were 33 latency aged children who exhibited behavioral characteristics of the severely disturbed (Appendix B).

The steering committee met to discuss the results of all findings to date. With 69 identified latency aged severely disturbed children in need of intervention services, it was the consensus of both agencies to proceed with plans for a school-based therapeutic/educational program.

The Center's Executive Director arranged a meeting to present the program proposal to the Executive Board and the Mental Health/Mental Retardation County Administrator. As a result of this presentation the program was fully endorsed and subsequently funded by the county program office.

The intermediate unit secured space within a school site with adequate provisions to house the academic activities (multi-classroom, non-graded structure; an extra-curricular

room for art and music; a gymnasium for physical education; and a cafeteria/lunchroom. Space for the on-site psychiatric services for students on an individual and group therapy basis and administrative office facilities were provided by the mental health center. Student transportation and meals were provided by the school district.

The County Mental Health Office applied to the Western Field Office for licensure and the Labor and Industry Occupational Certificate. Pending approval of a provisional license, the committee proceeded with program planning.

Upon approval of licensure, staff recruitment was undertaken. The intermediate unit provided a certified SED teacher and a qualified aide. The mental health center provided a psychiatrist, program director, therapist and a case manager (Appendix E).

Initial staff training included three seminars. One for the therapeutic staff conducted by the psychiatrist; one for the educational staff conducted by the IU Program Supervisor. A joint seminar with both components was conducted by the program director and stressed component integration strategies and treatment team case management procedures.

Integration of the therapeutic and educational components merged under the following policy:

The educational component was based upon an Individual Education Plan (IEP) for each student. The student was expected to attain an 80th percentile ranking in each academic area. Core subjects of the State Elementary Mandated Curriculum included: Reading, Math, Language, Spelling, Science, Health, Social Studies, Physical Education, Art and Music. The Educational component was under the supervision of the intermediate unit Director of Special Education (Appendix E).

The therapeutic component was based primarily upon group therapy treatment which included social skills, insight groups and expressive activities. Individual therapy and chemotherapy were offered as needed. Family involvement was stressed throughout the program. All of these treatment modes were under the supervision of the psychiatrist (Appendix E).

Today, case management is recognized as one of the most essential services in alternative programs and was an intricate part of integrating the therapeutic and educational components. Case management is defined as a set of functions designed to achieve the following outcomes: assess appropriate client needs for services, to design a service plan (not a treatment plan) and to assure implementation and coordination of that plan. The goals were to assure the appropriate fit of services with clients, to improve client functioning, to assure continuity of care, and to identify necessary resources. According to the Task Panel on Deinstitutionalization, Rehabilitation and and Long-Term Care of the President's Commission on Mental Health, "Strategies focused solely on organizations are not

enough. A human link is required. A case manager can provide this link and assist in assuring continuity of care and a coordinated program of services."

Ongoing staff training included inservice training for all professional staff members through a combination of methods which included:

1. At least one monthly in-house training conference, from one to two hours in duration, with the program's supervising psychiatrist to provide specific information pertinent to immediate staff needs.
2. Participation in staff training programs conducted by the mental health center and the intermediate educational unit.
3. Participation on a staff rotating attendance basis in specialized workshops and training seminars provided by area universities, professional associations, and/or human services agencies. Workshop information was shared with all program staff by the delegate who attended the workshop.

The intermediate unit sponsored two meetings to allow the school-based staff to introduce the program to:

1. Parents/guardians of identified students
2. Receiving school faculty.

The staff members made site visitations to alternate programs and invited other program staff members to visit this practicum site to benefit from the expertise and experience of their colleagues.

An enrollment of 15 children from the mental health center and the intermediate unit was compiled. A student referral form was completed for each student and a signed parental consent form was obtained. The intermediate unit also obtained referred students' school records. A waiting list from the MH Center, the IU, as well as the community human services agencies was kept and clients on the waiting list were admitted to the school-based program according to their therapeutic/educational needs.

The program psychiatrist and the mental health center's psychologists administered psychiatric and psychological evaluations to the identified students. The program teacher and the therapists administered therapeutic evaluations and academic pre-tests.

The program director developed effective community relations through a series of activities to inform the public of the program goals, activities, and policies in an attempt to create public opinion favorable toward the program and its mission. These public relations activities included: distribution of a concept paper, newsletters, and brochures, student recruitment, serving on advisory boards, and personal interaction of staff and board members with those in the community.

The program followed the school calendar and began operation September 1, 1987. Academic classes and therapeutic treatment sessions were scheduled simultaneously throughout

the school day (Appendix F). State inspectors performed an on-site evaluation and approved the program for licensure.

A home/school visitation component included parent meetings at the school site to discuss the IEP with the staff teacher and the Treatment Plan/Reviews with the staff therapists; parent/teacher/therapist telephone consultations for parent guidance and crisis intervention; therapist home visitations to correlate the family/school component.

A direct link with the Children and Adolescent Service System Program (CASSP) was established. CASSP has been developed to assure the seriously emotionally disturbed student of getting the best services to meet his/her specific needs in the least restrictive environment. CASSP is also an advocate to ensure the rights of the child and the family. Through this program contacts were made for the parents to meet with their local state representatives to advocate for appropriate changes or additions to the system.

The writer participated in the concept development paper and serves on the advisory board of the newly funded Home-builders Outreach Program for Emotionally Disturbed Children and their families (HOPE). The HOPE Network is a collaborative effort of CASSP affiliated agencies in this county.i.e., Mental Health, Children and Youth, Juvenile Probation Office, Drug and Alcohol Commission, and the Intermediate Unit #1. This systems approach is based on the belief that mentally ill children deserve "whatever it takes" to enable them to

achieve their potential within the natural environment of their own home and family. Therapeutic teams (in concert with consulting psychiatrist, nurse, and behavior specialist) provide intensive, in-home assessment and intervention services to stabilize the family unit, provide a broad range of therapeutic services, facilitate access to a variety of relief services, and empower families to mobilize personal and community resources. This school-based therapeutic educational program (STEP) has access to the services of the HOPE Network as needed.

Following 4 months of operation a community awareness open house was held at the school site for staff members from the MH center, IU, CASSP participating agencies, students and parents.

After 6 months of the STEP operation, target students were again tested on the original testing instruments to measure the effectiveness of the school based program as a major intervention and rehabilitation strategy for severely disturbed children.

Referral of the students back to the mainstream was initiated by team discharge staffings. The teacher set up meetings with school representatives, arranged for observations and visits by the receiving school staff, and initiated direct contact with the student's future teachers. The therapists participated in this planning but took their cues from the teacher regarding the student's readiness for return to the

regular school. The program therapists followed students mainstreamed to their home schools on a weekly basis. Parents, too, had direct access to the teaching/therapeutic team regarding discussion of the program and questions of school re-entry.

Meetings were scheduled with each districts' guidance counselor to review the results of the program and recruit referrals for the next school year.

Calendar Plan

January 1987
- Met with Community Mental Health Center and Intermediate Unit Steering Committee to develop plans for expanding services to the target population.
- The writer was named Program Director.
- Visited existing alternative program sites to compile preliminary data.

February 1987
- Needs assessments were compiled by the MH Center and IU.
- Met with MH Center and IU to review assessment findings.

March 1987
- Program was approved and funded by the Mental Health/Mental Retardation County Program Office.
- Intermediate Unit secured the school site and supportive services.
- MH/MR Program Office applied to the state for licensure, Labor and Industry Occupational Certificate, and Medical Assistance approval.

April 1987
- Received provisional license and medical assistance approval.
- Recruited and trained staff.
- Met with MH Center and IU to identify target students.

May 1987
- Met with parents of identified students to introduce the program and complete consent forms.
- Met with school faculty to introduce the program.

June 1987 - Psychological and psychiatric evaluations were administered to all students.
- Pre-academic tests and therapeutic evaluations were administered.

July 1987 - Developed a program concept paper and program brochures.
- Circulated newsletter, concept paper and brochures to key public figures and human services agents.

August 1987 - Held pre-program planning meetings with staff.
- Prepared school site.

September 1987 - Prepared and reviewed Individualized Education Plan with students and parents.
- Prepared and reviewed Treatment Plan with students and parents.
- On-site evaluation by Department of Public Welfare to secure full licensure.

October 1987 - Administered sociogram to all students. Prepared academic and therapeutic schedules.

November 1987 - Began home/school visitation component.
- Established direct link with Children and Adolescent Service System Program (CASSP).

December 1987 - Held open house at program site for staff from the MH Center, IU, CASSP participating agencies and students and parents.

January 1988 - Established direct link with the Homebuilders Outreach Program for Emotionally Disturbed Children and their families (HOPE).

February 1988 - Post-academic/therapeutic tests and evaluations were administered.

March 1988 - Held discharge staffings.
- Met with receiving school staff.
- Met with school districts' guidance counselors to review program data and recruit student referrals for fall 1988.

Chapter V

RESULTS, CONCLUSIONS and RECOMMENDATIONS

Results

Subjects

There is no consistent definition of, or eligibility criteria for, serious emotional disturbance. For this and many other reasons, many children with serious emotional disturbance are never identified and consequently do not receive services they require.

The initial admission criteria for this practicum program included target students who have the ability to attain the eightieth percentile in academic achievement and respond to intense therapy. However, in order to determine the feasibility of including exceptionalities other than the socially/emotionally disturbed (SED) an experimental group were added to the population, i.e. 3 dual diagnosed students: 1 gifted/socially-emotionally disturbed (SED), 1 trainable mentally retarded (TMR)/ socially-emotionally disturbed, 1 educable mentally retarded-borderline (EMR)/socially-emotionally disturbed. Additionally, 1 learning disabled (LD) student and 2 SED students with a single diagnosis were admitted to the program. The remaining 6 students came from regular classrooms and had no prior diagnoses. The thirteen and fourteen year old did not fit the latency age criteria but were also included in the program on an experimental basis.

Table 1 shows information related to sociometric rankings administered within the first two weeks of the program (pre) and again following six months of program participation (post).

TABLE 1

Sociometric Rankings of Positive and Negative Student Ratings by Percentage

Student	Age	Sex	Positive Pre	Positive Post	Percent Inc/Dec		Negative Pre	Negative Post	Percent Inc/Dec	
A	8	M	1	10	.90	.0	4	4	.0	.00
B	8	M	0	11	1.00	.0	8	2	.0	.75
C	8	M	8	15	.47	.0	1	0	.0	1.00
D	9	F	1	11	.91	.0	2	2	.0	.00
E	9	M	1	13	.92	.0	6	2	.0	.66
F	10	F	0	12	1.00	.0	3	0	.0	1.00
G	10	M	1	13	.92	.0	3	3	.0	.00
H	10	M	1	14	.93	.0	3	2	.0	.33
I	10	M	0	13	1.00	.0	2	0	.0	1.00
J	10	M	1	10	.90	.0	2	2	.0	.00
K	11	M	1	2	.50	.0	1	5	.80	.00
L	11	M	1	1	.00	.0	5	9	.44	.00
M	11	M	1	3	.66	.0	4	5	.20	.00
N	13	M	7	15	.53	.0	1	1	.0	.00
O	14	F	1	12	.92	.0	3	0	.0	1.00

J = Gifted and SED
K = TMR and SED
L = EMR (borderline) and SED
M = LD
G-H = SED
A-B-C-D-E-F-I-N-O = Regular Class
N = 13 year old
O = 14 year old

A student questionnaire of 6 items asked the students to rate their classmates on a Likert-type scale numbered 1 through 6, where 6 indicated the highest rating (very best friends); 3 the middle rating (don't know them) and 1 the lowest rating (dislike them). The specific items are listed in Appendix C. Items 6,5,and 4 were designated as positive responses. Items 3,2, and 1 were designated as negative responses. The individual tally of responses are listed in Appendix G.

The objective for the sociometric rating was: 12 of the 15 students would attain a 90% increase in social skills as measured by the number of students who responded positively toward their classmates. Students K,L, and M ranked below the 90% objective with 50%, 0%, and 66% respectively. Students C and N ranked below the 90% objective. However, because approximately one-half the students ranked them positively on the pre test it was impossible for these students to attain a 90% increase. Since all 15 students responded positively toward them on the post test, it was considered that they attained a 100% increase in social skills.

With 12 of the 15 students increasing their social skills by 90% or more the objective was met.

Data from the Level of Functioning (LOF) ratings were compiled in terms of pre and post social/emotional objectives as measured by the number of treatment objectives achieved (goal attainment scale).

Table 2 contains information related to student level of functioning ratings administered within the first two weeks of the program (pre) and again following 6 months of program participation (post).

TABLE 2

Level of Student Behavioral Functioning
as Measured by the
Goal Attainment Scale

Student	Age	Sex	Objectives	Achieved	%Increased/Decreased	
A	8	M	24	22	.92	.0
B	8	M	28	26	.92	.0
C	8	M	22	22	1.00	.0
D	9	F	27	25	.93	.0
E	9	M	30	28	.93	.0
F	10	F	24	23	.96	.0
G	10	M	30	27	.90	.0
H	10	M	29	27	.93	.0
I	10	M	27	26	.96	.0
J	10	M	30	27	.90	.0
K	11	M	30	22	.73	.0
L	11	M	30	2	.07	.0
M	11	M	29	21	.72	.0
N	13	M	26	26	1.00	.0
O	14	F	25	23	.92	.0

Goal Attainment Scale

1. Self
2. Peer
3. Family
4. Adult Authority
5. Task Performance
6. Social/Emotional

Note: Pre objectives vary according to student need

A therapist designed treatment plan (Appendix D) covering 6 goal subscales (Self, Peer, Family, Adult Authority, Task Performance, Social/Emotional) served as the basis for the ratings implying degree of functioning. The individual tally of results are listed in Appendix H. The 2 therapists served as observers of each other's case load and the program director served as observer of all 15 students to verify goal attainment.

The ratings of students K,L, and M ranked below the 90% objective with 73%, 7%, and 72% respectively. With 12 of the 15 students decreasing their behavioral disorders by 90% or more the LOF objective was achieved.

The goal of the academic achievement objective was to have the students increase one grade level (9 months) by the end of the school year. Due to the fact that the Intermediate Unit needed the academic achievement results to plan discharge staffings and placements the tests were administered after 6 months of operation. Therefore, for the purpose of this report, 6 months is equal to one grade level.

Table 3 contains information related to the standardized Woodcock Reading Mastery Test, KeyMath Diagnostic Arithmetic Test, and Wide Range Achievement Test, which measured the increase or decrease in academic performance. Individual scores are listed in Appendix I.

TABLE 3

Pre and Post Academic Achievement
of Students by Grade Level

Student	Age	Sex	Reading Increase yr.mo.	Math Increase yr.mo.	Spelling Increase yr.mo.
A	8	M	10	10	7
B	8	M	8	8	2.5
C	8	M	5	0	0
D	9	F	6	6	6
E	9	M	7	7	6
F	10	F	1.5	7	7
G	10	M	1.3	7	6
H	10	M	6	1.1	6
I	10	M	6	6	2.3
J	10	M	6	6	6
K	11	M	5	0	(-2)
L	11	M	1.2	6	6
M	11	M	1.1	4	3
N	13	M	3.1	1.6	2.3
O	14	F	5.7	1.1	7

J = Gifted and SED
K = TMR and SED
L = EMR (borderline) and SED
M = LD
G-H - SED
A-B-C-D-E-F-I-N-O = Regular Class
N = 13 year old
O = 14 year old

Students K and M rated below the 1 grade level objective with Reading 5 month increase, Math 0 month increase and Spelling -2 month decrease and Math 4 month increase, Spelling 3 month increase respectively. Student M did increase 1.1 year in Reading but did not increase 1 grade level overall.

With 12 of the 15 students increasing their academic performance by 1 grade level (6 months) the academic objective was achieved.

Conclusions

The findings indicate that certain categories of exceptional children do not respond to intense daily therapeutic intervention, i.e., students K (TMR/SED), L (EMR-borderline/SED), and M (LD). Since only the EMR -borderline student, who is functioning 2 years behind grade level, responded minimally to the academic component it would appear that these 3 categories of exceptional children would receive equal benefit in their specific special education programs. Students G and H, who were singly diagnosed as SED prior to admission, increased significantly in all areas.

Student C, who was diagnosed as attention deficit disorder without hyperactivity responded 100% to therapy but exhibited slow learner tendencies in the academic area. It would appear that additional study of this type student is needed.

There were 9 students admitted to the program who were undiagnosed in the regular class but were referred by the Mental Health Center as seriously emotionally disturbed, i.e., students A,B,C,D, E,F, I,N, and O. Such children traditionally do not do well in regular SED placement. Consequently these children are "falling through the cracks" and are underserved.

Student N (13 year old male) and student O (14 year old female) were admitted to the program in an attempt to fill a service gap between the STEP program and the Center's adolescent program servicing ages 14 through 18. The 13 year old increased in all areas with exerted effort to keep him involved with his peers at his Junior High School through participation in sports. After 6 months it was obvious that this student had developed beyond the latency age and was in need of normal, age-appropriate peer relationships. It was a team decision to return Student N to his home school with weekly follow up visits by his STEP therapist. This arrangement is now in the experimental stage.

For the first 6 months the 14 year old female increased in all areas. Shortly thereafter she began to show signs of regression into social phobia, avoidance disorder, and agoraphobia with panic attacks. Due to the severity and chronicity of the symptoms and the downward course, she was referred for an in-patient psychiatric evaluation.

It is concluded that the primary population for a latency aged school-based therapeutic/educational program is single diagnosed seriously/emotionally disturbed students and students from regular class referred by the mental health center as seriously emotionally disturbed.

The future success of this program depends on recruiting students in the latency age (8 through 12). Older students in this setting require considerable individual time and planning. This deters from quality time spent with the target population.

Early identification of students with serious behavioral and/or emotional problems clearly deserves high priority. The writer is optimistic that the STEP program will indeed lead to improved services for this needy population of students.

Recommendations

Results of the implementation were positve. The enthusiasm of the teachers, therapists, students, and parents was indeed stimulating. The sense of common purpose and commitment to improving services to school children with behavioral or emotional disorders has been substantial.

The area most clearly in need of further investigation in this practicum program is the integration of the mental health and educational services. The lack of integration can be seen through the ill-defined role of the mental health worker in the classroom.

Further investigation might involve a survey of educators currently working at mental health/school sites, as well as higher level discussion between Department of Education and Office of Mental Health officials. Perhaps the most appropriate vehicle for this investigation would be an interdepartmental task force.

Parent involvement was a prime concern in the development of this program. There is a need to help parents become informed decision makers. More important, however, is the possibility of coordinated lobbying efforts in the area of parental empowerment. Further development of a strong parent advocacy group attached to this program is recommended.

Student transportation presented another area of concern. Being the first and only program of its kind within 6 school districts, transporting students outside their district was very costly and the long distances traveled by the students was fatiguing. Excessive travel time and distances were also problems for parents who wanted to be involved in their child's educational and treatment program. Since there is a student waiting list in each school district, further investigation might be given to implementing a STEP program in each of the remaining 5 districts to alleviate transportation problems.

Dissemination

In correspondence with the state Director of Special Education the STEP program has been commended and the state director has asked to be kept informed of the program's progress.

At the public forum on the Mental Health System, conducted by Martha B. Knisley, state Secretary of Mental Health, two parents and the director of STEP gave testimony advocating the need for innovative mental health treatment approaches and alternative schooling for seriously emotionally disturbed children.

The program's Intermediate Unit team teacher received a state Education Department high technology mini-grant to improve the education of students with disabilities. In making the presentation, state Secretary of Education Thomas K. Gilhool said, "These mini-grants will provide teachers in every area of Pennsylvania with equipment that brings new opportunities for learning to students with disabilities.

The STEP program will be extended into an 8-week summer day program for children with behavioral, emotional, and learning problems from June 20 through August 12.

The present STEP program will continue at its present site for the 1988-1989 school year. Plans are being studied to start a second STEP program in another school district in the fall of 1988.

A study by Grosenick, George, and George (1988) indicated that relatively few comprehensive program descriptions are available to program planners and developers in the field of seriously emotionally/behaviorally disturbed students. While many high quality programs are likely to exist in the field, they have not been adequately described on paper.

This program documentation may be helpful to districts in the beginning stage of developing a school-based therapeutic/educational program.

REFERENCES

Arnove, R.R., & Strout, T. (1980). Alternative Schools for Disruptive Youth. The Educational Forum, 44 (4), 453-71

Barr, R.D. (1976). Curriculum in Alternative Schools, (Paper presented at the National Institute of Education Conference on Policy Issues in Educational Options, Chicago, Illinois, June-July.

Council for Children with Behavioral Disorders. (1987). Reston: Virginia.

Cullinan, D., Epstein, M.H., & Lloyd, J.W. (1983). Behavior Disorders of Children and Adolescents. Englewood Cliffs, N.J.: Prentice Hall.

Diagnostic and Statistical Manual of Mental Disorders (DSM III). (1980) American Psychiatric Assn.: Washington, DC.

Epstein, M.H., & Olinger, E. (1987). Use of Medication in School Programs for Behaviorally Disordered Pupils. Journal of the Council for Children with Behavioral Disorders. 12 (2), 138-45

Glasscote, R.M., Fishman, M.E., & Sonis, M. (1972). Children and Mental Health Centers. Washington, D.C.: The National Association for Mental Health.

The Joint Information Service of the American Psychiatric Association, (1974). Washington, DC.

Will, M.C. (1984). Let us pause and reflect: Washington shares the blame. The Heritage Foundation Backgrounds. Washington, DC: The Heritage Foundation.

BIBLIOGRAPHY

Anderson, L.S., & Limoncelli, R.J. (1982). Meeting the Needs of the High Risk, Difficult to Reach Student: Creative Educational Approaches. The School Counselor, 29,(5)381-87.

Axelrod, S., & Bailey, S.L. (1979). Drug Treatment for Hyperactivity: Controversies, Alternatives, and Guidelines. Exceptional Children. 45, (7), 544-50.

Baemen, R.W., Stephens, N.Q.P., & Glenwick, D.S. (1986). Outcome in psychoeducational day school programs: A Review. American Journal of Orthopsychiatry, 56, 263-270.

Baker, B.L., & Brightman, R.P. (1984). Children, Mental Health, and the Law. Beverly Hills, CA: Sage Publications.

Berger, M. (1974). Violence in the Schools: Causes and Remedies. Bloomington, IN.: Phi Delta Kapp.

Behar, L. (1986). The North Carolina Experience. Children Today. May-June, 16-21.

Berkovitz, I.H. Expanding Mental Health Interventions in Schools. Mental Helath Professionals, (1), 1985

Bloom, B.S. (1984). Taxonomy of Educational Objectives: Cognitive Domain. New York: Longman, Inc.

Brendtro, L.K., Ness, A.E., & Milburn, J.F. (1979). Psychoeducational Management: Individualizing Treatment. Re-Educating Troubled Youth. LXIV.

Browne, T., Stotsky, B.A., & Eichorn, J. (1977). A selected comparison of psychological, development, social and academic factors among emotionally disturbed children in three treatment settings. Child Psychiatry, 7, 231-53.

Campbell, N.J., Dobson, J.E, Bost, J.M. (1985). Educator Perceptions of Behavior Problems of Mainstreamed Students. Exceptional Children, 51, (4), 298-303.

Carroll, I., & Williams J. (1982) Clinical and Administrative Applications and Implications After One Year's Utilization of the Farmington Funcitonal Assessment Scale. International Journal of Hospitalization.

Cohen, H.L., Filipczak, A. (1977). A New Learning Environment. San Francisco: Jossey-Bass, Inc.

Cohen, M.G. (1980). Germantown, A Community study. Unpublished manuscript, Boston University School of Social Work.

Conners, C.K., & Werry, J.S. (1979). Pharmacotherapy. In H.S. Quay & J.S. (Eds.). Psychopathological disorders of childhood. (2nd ed.) 336-86. New York: Wiley.

County Office of Employment Security (March, 1983).

Davis, R.W. Uhler, R., & Kelly, L.J. (1986). Strategies and Self Instruction for Behaviorally Disordered Students: A Direct Instruction Approach. The Directive Teacher, 8 (1), 18-19.

Department of Public Welfare (1985). Harrisburg, Penna.

Economic Profile, County Development Council (March, 1982).

Erikson M. (1978). Child Psychology:Assessment, Etiology, and Treatment. New Jersey: Prentice-Hall.

Eyde, D.R., DeSalvo, C.G., & Riley, M.L. (1983). The Role of Psychiatric Service. The Directive Teacher. 5 (1), 4-19.

Forness, S.R. & Cantwell, D.P. (1982). DSM III Psychiatric Diagnosis and Special Education Categories. The Journal of Special Education. 6, 49-63.

Gadow, K.D. (1986). Fundamental Concepts in Pharmacotherapy: An Overview. In K.D. Gadow (Ed.), Children on Medication: Emotional Disturbance and Adolescent Disorders. San Diego: College-Hill.

Gerber, M. (1984). Is Congress getting the full story? Exceptional Children, %L (3), 209-24.

Grosenick, J.K., George, N.L., & George, M.P., (1988). The Availability of Program Descriptions Among Programs for Seriously Emotionally Disturbed Students. Behavior Disorders. 13 (2), 108-115.

Guralnick, J.J. (1982). Pediatrics, special education, and handicapped children: New relationships. Exceptional Children, 48, 294-9[illegible].

Hewett, F.M. & Forness, S.R. (1984). Education of Exceptional Learners, (3rd ed.). Boston: Allyn & Bacon.

Hirchberg, J.C. (1977). The role of education in the treatment of emotionally disturbed children through planned ego development. American Journal of Orthopsychiatry. 23, 684-90.

Hobbs, N. (1978). Perspectives on re-education. Behavior Disorders. 3 (2), 65-66.

Johnson, T.E., Chandler, L.K. Kerns, G.M. & Fowler, S.A., (1986). What are parents saying about family involvement? Exceptional Children, 11, 10-26.

Kadis, A.E. (1983). Psychiatric diagnosis: dimensions of dysfunction and child behavior therapy. Behavior Therapy. 32-33.

Kennedy, J. Mitchell, J.B., KLerman, L.V. & Murray, A. (1976). A Day School Approach to aggressive Adolescents. Child Welfare. 55 (10), 712-24.

Keymath Diagnostic Arithmetic Test, American Guidance Service. Inc., Circle Pines, Minn. 55014.

Levin S. Scotch, N.A. & Vlasak. J. (1979). Unraveling Technology and Culture in Public Health. American Journal of Public Health. LIX.

Lewis, D.O., & Balla, D. (1976). Sociopathy and its synonyms: Inappropriate Diagnoses in Child Psychiatry. American Journal of Psychiatry. LXXXII.

London, P., Character Education and Clinical Intervention: A Paradigm Shift for U.S. Schools. Phi Delta Kappan. 68 (9) May, 1987.

Long, K.A., & McQueen, D.V. (1984). Detection and Treatment of Emotionally Disturbed Children in Public Schools: Problems and Theoretical Perspectives. Journal of Clinical Psychology. 40 (1), 378-90.

Martinson, M.D. (1982). Interagency services: A new era for an old idea. Exceptional Children, 48, 389-94.

Moore, D.N., Bloom, B.L., Gaylen, S., Pepper, M., Pettus, C., Willis, E.M. & Bohn, A.K. The Rates-Under-Treatment Approach, NIMH, Needs Assessment Approaches: Concepts and Methods. DHEW Publication No. (ADM) 72-77, 1977.

National Library Association (1986). Washington, DC.

Payne, R., and Murray, C. (1974). Principals Attitudes Toward the Intergration of the Handicapped. Exceptional Children, 41, 123-25.

Prehm, H.J. & McDonald, J.E. (1979). The Yet to be Served: A Perspective. The Council for Exceptional Children. 45 (7), 502-507.

Pryzwansky, W.B. (1981). Mandated team participation: Implications for psychologists working in the school. Psychology in the Schools. 18, 460-66.

Pyecha, J. (1979). A national survey of individualized education programs (IEP) for handicapped children. Research Triangle, NC: Research Triangle Institute.

Ray, B.M. (1985). Measuring the Social Position of the Mainstreamed Handicapped Child. Exceptional Children, 52 (1), 57-62.

Redl, F., & Wineman, R. (1952). Controls from Within. New York: Harcourt, Brace and World.

Rhodes, W.D. (1982). Behavioral Threat and Community Response.

Richmond, J.B. (1983). Public Policy, Children, and Families. Peabody Journal of Education, 60 (3), 27-32.

Rolf, J. (1976). Peer status and the directionality of symptomatic behavior: Prime social competence predictors of outcome for vulnerable children. American Journal of Orthopsychiatry. 46, 74-88.

Ross, A.L., & Schreiber, L.J. (1975). Bellefaire's Day Treatment Program: An Interdisciplinary Approach to the Emotionally Disturbed Child. Child Welfare, 44 (3), 183-94.

Scanlan, C.A., Arick, J., & Phelps, N. (1981). Participation in the development of the IEP: Parents' perspective. Exceptional Children, 47, 373-74.

Schenck, S.J. (1980). The diagnostic/instructional link in individualized education programs. The Journal of Special Education, 14, 337-45.

Sinclair, E. (1980). Relationship of psychoeducational diagnosis to education placement. Journal of School Psychology, 18, 349-53.

Sinclair, E. & Kheifets, I. (1982). Use of clustering techniques in deriving psychoeducational profiles. Contemporary Educational Psychology. 7, 81-89.

Sinclair, E., Forness, S.R., & Alexson, J. (1985). Psychiatric Diagnosis: A Study of its Relationship to School Needs. The Journal of Special Education. 19 (3), 333-44.

Sinclair, E, & Alexson, J. (1985). Creating diagnostic related groups: A manageable way to deal with DSM III. American Journal of Orthopsychiatry. 55, 426-33.

Smith, V., Barr R., & Burke, D. (1976). Alternatives in Education. Bloomington, IN.: Phi Delta Kappa.

Smith, B.J., & Schakel, J.A. (1986). Noncategorical Identification of Preschool Handicapped Children: Policy Issues and Options. Journal of the Division for Early Childhood Exceptional Children. 11 (1), 78-86.

Sparks, G., Nowakowski, M. Hall, B., Alec, R., & Imrick J. (1985). School improvement through staff development. Educational Leadership. 42, 59-61.

Stainback, W., & Stainback, S. (1984). A rationale for the merger of special and regular education. Exceptional Children, 51 (2), 102-11.

The Pennsylvania County Data Book (June, 1982). Department of Commerce, Harrisburg, PA.

Thurlow, M.I., & Ysseldvke, J.E. (1982). Instructional Planning: Information collected by school psychologists vs. information considered useful by teachers. Journal of School Psychology. 20, 31-41.

Tureff, S.F., & Flieger, D. (1988). Teaching Behaviorally Disordered Youth, Council for Children with Behavioral Disorders. 3, 4-12.

Turnbull, A.P. (1983). Parent professional interactions. In M.E. Snell (Ed.). Systematic instruction of the moderately and severely handicapped (2nd ed.). Columbus, OH: Charles E. Merrill.

Tyne, T.F., & Flynn, J.J. (1981). Teacher Nominations and Peer Evaluations in the Identification of Socio-emotional At-Risk Students. Exceptional Children. 48 (1), 66-68.

United States Census Bureau. (1980). Washington, D.C.

United States Department of Education. (1984). To assure the free appropriate public education to all handicapped children: Sixth Annual Report to Congress on the Implementation of Public Law 94-142: The Education for All Handicapped Children Act. Washington, DC: Department of Education.

Vacc, N.A., & Kirst, N. (1977). Emotionally Disturbed Children and Regular Classroom Teachers. The Elementary School Journal. 3, 313-17.

VanDenBerg, J., & Donner, R. (1986). Parents and Mental Health Progress: Working Together in Kansas. Children Today, May-June.

Wallace, R.E. (1983). Legal Rights and Mental Health Care. Lexington, Mass: D.C. Heath & Company.

Wide Range Achievement Test (WRAT). Jastak Associates, Inc. Wilmington, Delaware.

Wiegerink, R., Hocutt, A., Posante-Loro, R., & Bristol, M. (1980). Parent involvement in early education programs for handicapped children. In J.J. Gallagher (Ed.). New directions for exceptional children: Ecology of exceptional children. San Francisco: Jossey-Boss.

Williams F., & Coleman, M. (1982). A follow-up study of psychoeducational recommendations. Journal of Learning Disabilities. 15, 95-105.

Williams, R.P. (1982). The ED Primary Student: An Approach That Works. Academic Therapy 18 (2), 217-23).

Wilson, M.D., Evans, M.B., Dawson, R.L. & Kiek, J.S. (1977). Disturbed Children in Schools. Special Education: Forward Trends, 4 (2), 8-10.

Woodcock Reading Mastery Tests. American Guidance Service, Inc. Circle Pines, Minn. 55014.

APPENDIX A

NEEDS ASSESSMENT

RATES-UNDER-TREATMENT

Needs Assessment Rates-Under-Treatment

Diagnosis (DSM III)

Axis I (Clinical Psychiatric Syndrome)

		Age	Students	M	F	Percent
314.01	Attention Deficit Disorder with Hyperactivity	8	9	6	3	25.0
		9	5	5	0	13.8
		10	11	11	0	30.7
		11	5	5	0	13.8
		12	6	5	1	16.7
	mean age	10	36	32	4	100.0

Axis II (Personality & Development Disorder)

		Age					Total	M	F	Percent
		8	9	10	11	12				
312.00	Disturbance of Conduct	1	2	3	1	1	8	7	1	22.0
312.34	Intermittent explosive Disorder	1	1	2	2	2	8	8	0	22.0
312.90	Unspecified Disturbance of Conduct	1		1			2	2	0	5.5
313.00	Disturbance of Emotions specific to Childhood and Adolescence			1			1	1	0	2.9
313.81	Oppositional Disorder		1	1	1	3	6	6	0	16.8
313.90	Unspecified emotional Disturbance of childhood or adolescence	2		2	1		5	5	0	13.9
314.01	Hyperkinetic Syndrome of Childhood with Hyperactivity	4	1	1			6	3	3	16.8
		9	5	11	5	6	36	32	4	100.0

36 Students identified as severely disturbed

APPENDIX B

NEEDS ASSESSMENT

REFERRAL - QUESTIONNAIRE

Needs Assessment Referral-Questionnaire

Behavioral Characteristics	8 yrs. (2 S)	9 yrs. (3 S)	10 yrs. (9 Students)	11 yrs. (8 Students)	12 yrs. (11 Students)	Total	Percent
Overly Active	x x	x	x x x x x x x x x	x x x x x x x x	x x x x x x x x x x x	23	.69
Reading (Underachievement)	x x	x	x x x x x x x x x	x x x x x x x x	x x x x x x x x x x x	26	.78
Arithmetic (Underachievement)	x	x	x x x x x x x x	x x x x x x x x	x x x x x x x x x x	23	.69
Spelling (Underachievement)	x x	x	x x x x x x x x x	x x x x x x x x	x x x x x x x x x x x	26	.78
Confusion about Instruction	x x	x x	x x x x x x x x x	x x x x x x x x	x x x x x x x x x x x	27	.81
Explosive or Aggressive	x	x x x x x x x	x x x x x x x x x	x x x x x x x x	x x x x x x x x x x x	28	.84
Peer group relationship poor	x x	x x x x x x x	x x x x x x x x	x x x x x x x x	x x x x x x x x x	23	.69
Short attention span for age	x x	x x x x x x x	x x x x x x x x	x x x x x x x x	x x x x x x x x x	23	.69
Does not accept adult authority	x	x x x x x x x	x x x x x x x x	x x x x x x x x	x x x x x x x x x	25	.75
Poor school/parent relationship	x x	x x x x x x x	x x x x x x x x	x x x x x x x x	x x x x x x x x x	29	.87
Withdrawn behavior	x		x x			3	.09
Anti-social behavior	x x	x x x	x x x x x x x x	x x x x x x x x	x x x x x x x x x	25	.75
Oppositional behavior	x	x x x x x x x	x x x x x x x x x	x x x x x x x x	x x x x x x x x x	28	.84

33 Students identified as severely disturbed

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APPENDIX C

SOCIOMETRIC MEASUREMENT FORM

HOW I FEEL TOWARD OTHERS

This is a list of your classmates. Put a number opposite each classmates name: 6 5 4 3 2 1

	Pre		Post	
	Reg.	SEM	Reg.	SEM
6. My very best friends				
5. My other friends				
4. Not friends but okay				
3. Don't know them				
2. Don't care for them				
1. Dislike them				

The scale was a Likert scale, 6= "very best friends," 3= "don't know them," 1= "dislike them."

APPENDIX D

GOAL ATTAINMENT FORMS

TREATMENT PLAN

TREATMENT PLAN REVIEW

TREATMENT PLAN

Name: _____ BSU # _____

BEHAVIORAL

1. SELF

Annual Goal:

Date:	Problems:	Short Term Goals	Methods	Target Date:	Achievement Date:

Note: Criteria for goal attainment is ____% unless otherwise noted.

2. PEERS

Annual Goal:

Date:	Problems:	Short Term Goals	Methods	Target Date:	Achievement Date:

Note: Criteria for goal attainment is ____% unless otherwise noted.

Name: _____ BSU #: _____

3. FAMILY

Annual Goal:

Date:	Problems	Short Term Goals:	Methods	Target Date:	Achievement Date:
Note:	Criteria for goal attainment is ___% unless otherwise noted.				

4. ADULT AUTHORITY

Annual Goal:

Date:	Problems	Short Term Goals:	Methods	Target Date:	Achievement Date:
Note:	Criteria for goal attainment is ___% unless otherwise noted.				

5. TASK PERFORMANCE

Annual Goal:

Date:	Problems	Short Term Goals:	Methods	Target Date:	Achievement Date:
Note:	Criteria for goal attainment is ___% unless otherwise noted.				

Name: _____ BSU#: _____

SOCIAL / EMOTIONAL

Annual Goal:

Note:	Problems	Short Term Goals	Methods	Target Date	Achievement Date

Note: Criteria for determing Social/Emotional goals is by the Level of Functioning goal attainment scale and clinical judgement of the psychiatrist and primary therapist.

Date:			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
	Therapist	Psychiatrist	Parent/Student

OUTPATIENT TREATMENT PLAN REVIEW

Patient: _____ Date of this Review: _____

A. Review of Previous Goals (O=Ongoing; M=Modified; A=Achieved; D=Deleted)

Goal #	Code	Comments
1		
2		
3		
4		

B. Additions to the Plan: Problems: | Goals: #

C. Revisions in Methods: _____

___ Review discussed with patient. Next Review Due: _____ (120 days)

___ No recent contact. Due to nature of original contact, case remains open.

_____ _____ M.D.
Primary Therapist Supervising Psychiatrist

==========

A. Review of Previous Goals Date of this Review: _____

Goal #	Code	Comments
1		
2		
3		
4		

B. Additions to the Plan: Problems: | Goals: #

C. Revisions in Mehtods: _____

___ Review discussed with patient. Next Review Due: _____ (120 days)

___ No recent contact. Due to nature of original contact, case remains open.

_____ _____ M.D.
Primary Therapist Supervising Psychiatrist

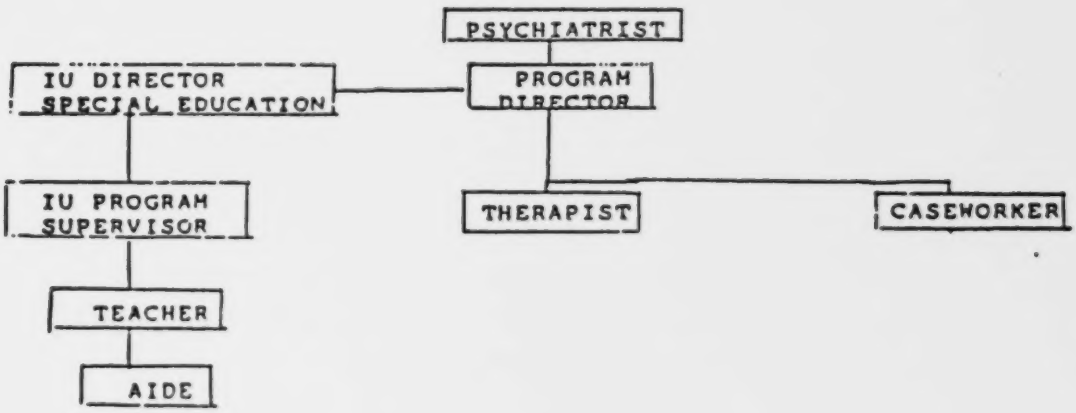
APPENDIX E

SCHOOL-BASED THERAPEUTIC/EDUCATIONAL PROGRAM

TABLE OF ORGANIZATION

STAFF

Table of Organization



STAFF

Numbers, Hours Per Week, Qualifications, and Functions

1. Psychiatrist - one
    a. Hours: Will provide at least 9 hours per week of assigned time.
    b. Qualifications: Pennsylvania license; specialty in child psychiatry; experience with latency age preferred.
    c. Function: Clinical and medical responsibility for the treatment of each client.

2. Program Director - one
    a. Hours: Thirty-seven and one-half hours per week.
    b. Qualifications: Master's degree in a mental health related field; minimum of three years relevant postgraduate clinical experience including one year experience or training with children and youth mental health programs; administrative experience preferred.
    c. Function: Fiscal and administrative coordination of the program including the monitoring of service delivery to meet prescribed treatment plans; periodic review of client records to assess quality of case management; supervision of staff including coordination of inservice training programs; and individual care coordinator responsibility for a limited number of program clients.

3. Therapist - one
    a. Hours: Thirty-seven and one-half hours per week.
    b. Qualifications: Master's degree in a mental health related field; minimum of two years relevant clinical experience with children and youth mental health programs; experience with group therapeutic modalities preferred.
    c. Function: Individual care coordinator including case manager for a maximum of ten clients; facilitate implementation of psychiatric directives, therapeutic modalities; and recreational activities related to the client's treatment plans.

4. Caseworker - one

   a. Hours: Thirty-seven and one-half hours per week.
   b. Qualifications: Bachelor's degree in a mental health related field; minimum of two years relevant clinical experience with children and youth mental health programs; experience with group therapeutic treatment modalities preferred.
   c. Function: Individual care coordinator including case-manager for a maximum of 13 clients; cooperate in implementation of therapeutic modalities and recreational activities related to clients' treatment plans.

5. Teacher - one

   a. Hours: Thirty-seven and one-half hours per week.
   b. Qualifications: Pennsylvania certification in special education; minimum of two years of classroom experience with socially and emotionally maladjusted youth.

6. Aide - one

   a. Hours: Thirty-seven and one-half hours per week.
   b. Qualifications: High School Diploma; experience working with children; ability to coordinate assistance with teacher.

APPENDIX F

WEEKLY PLAN SHEET

WEEKLY PLAN SHEET

Week

TIME

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8:00 - 8:30	Bus Monitor T.S. II & I	Bus Monitor T.S. II & I	Bus Monitor T.S. II & I	Bus Monitor T.S. II & I	Bus Monitor T.S. II & I
8:30 - 10:45	Class & Ind. Therapy T. S. II & I	Class & Ind. Therapy T.S. II & I	Class & Ind. Therapy T.S. II & I	Class & Ind. Therapy T. S. II & I	Class & Ind. Therapy T.S. II & I
10:45 - 11:15	Therapeutic Phys. Activity T.S. II & I	Therapeutic Phys. Activity T.S. II & I	Therapeutic Phys Activity T.S. II & I	Therapeutic Phys. Activity T.S. II & I	Therapeutic Phys. Act. T.S. II & I
11:15 - 11:30	Prep/Lunch T.S. II & I	Prep/Lunch T.S. II & I	Prep/Lunch T.S. II & I	Prep/Lunch T.S. II & I	Prep/Lunch T.S. II & I
11:30 - 12:00	Lunch/Meds Director T.S. I	Lunch/Meds Director T.S. II	Lunch/Meds Director T.S. I	Lunch/Meds Director T.S. II	Lunch/Meds Director T. S. I
12:00 - 12:30	Social Skills Group T.S. II & I	Expressive Group T.S. II & I	Problem Solve Group T.S. II & I	Expressive Group T.S. II & I	Activities Group T.S. II & I
12:30 - 1:30 1:30 - 2:15	Class & Ind. Therapy T. S. II & I	Class & Ind. Therapy T. S. II & I	Class & Ind Therapy T. S. II & I	Class & Ind. Therapy T.S. II & I	Class & Ind Therapy T.S. II & I
2:15 - 2:30	Dismissal All Staff	Dismissal All Staff	Dismissal All Staff	Dismissal All Staff	Dismissal All Staff
2:30 - 3:00	Staffing All Staff	Staffing All Staff	Staffing All Staff	Staffing All Staff	Staffing All Staff
3:00 - 4:00	Clinical/ Adm. Duties All Staff	Clinical/ Adm. Duties All Staff	Clinical/ Adm. Duties All Staff	Clinical/ Adm. Duties All Staff	Clinical/ Adm. Duties All Staff

APPENDIX G

SOCIOMETRIC RANKINGS OF POSITIVE AND NEGATIVE STUDENT RANKINGS

Sociometric Rankings of Positive and Negative Student Ratings

			Pre						Post						Total Pre		Total Post		Increase	Decrease
			Positive			Negative			Positive			Negative								
Student	Age	Sex	6	5	4	3	2	1	6	5	4	3	2	1	Positive	Negative	Positive	Negative	Positive	Negative
A	8	M	1	0	0	2	1	1	3	6	1	1	2	1	1	4	10	4	9	0
B	8	M	0	0	0	2	3	3	5	3	3	0	1	1	0	8	11	2	11	6
C	8	M	5	2	1	1	0	0	9	4	2	0	0	0	8	1	15	0	7	1
D	9	F	1	0	0	1	1	0	8	2	1	1	1	0	1	2	11	2	10	0
E	9	M	1	0	0	5	1	0	6	5	2	1	1	0	1	6	13	2	12	4
F	10	F	0	0	0	2	1	0	7	4	1	0	0	0	0	3	12	0	12	3
G	10	M	0	1	0	2	1	0	8	2	3	1	2	0	1	3	13	3	12	0
H	10	M	1	0	0	1	2	0	6	4	4	1	1	0	1	3	14	2	13	1
I	10	M	0	0	0	1	1	0	9	3	1	0	0	0	0	2	13	0	13	2
J	10	M	1	0	0	1	1	0	6	3	1	0	1	1	1	2	10	2	9	0
K	11	M	1	0	0	0	1	0	0	0	2	3	1	1	1	1	2	5	1	0
L	11	M	1	0	0	1	1	3	0	0	1	3	3	3	1	5	1	9	0	0
M	11	M	1	0	0	1	2	1	0	2	1	2	3	0	1	4	3	5	2	0
N	13	M	4	2	1	1	0	0	9	4	2	0	1	0	7	1	15	1	8	1
O	14	F	1	0	0	1	1	1	6	3	3	0	0	0	1	3	12	0	11	3

6. My very best friends
5. My other friends
4. Not friends but okay
3. Don't know them
2. Don't care for them
1. Dislike them

APPENDIX H

LEVEL OF STUDENT BEHAVIORAL FUNCTIONING AS MEASURED BY THE GOAL ATTAINMENT SCALE

Level of Student Behavioral Functioning as Measured by the Goal Attainment Scale

Student	Age	Sex	Pre Objectives 1	2	3	4	5	6	Post Objectives 1	2	3	4	5	6	Total Objectives	Total Achieved	Total Ongoing
A	8	M	2	4	4	4	5	5	0	0	1	0	0	1	24	22	2
B	8	M	5	5	3	5	5	5	0	0	0	1	0	1	28	26	2
C	8	M	5	5	1	1	5	5	0	0	0	0	0	0	22	22	0
D	9	F	5	5	5	2	5	5	0	0	1	0	0	1	27	25	2
E	9	M	5	5	5	5	5	5	0	1	1	0	0	0	30	28	2
F	10	F	5	5	5	4	0	5	1	0	0	0	0	0	24	23	1
G	10	M	5	5	5	5	5	5	0	0	1	0	0	2	30	27	3
H	10	M	5	5	4	5	5	5	0	0	0	0	1	1	29	27	2
I	10	M	5	5	3	5	4	5	0	0	0	0	0	1	27	26	1
J	10	M	5	5	5	5	5	5	0	1	0	1	0	1	30	27	3
K	11	M	5	5	5	5	5	5	4	4	4	2	4	4	30	22	8
L	11	M	5	5	5	5	5	5	3	5	5	5	5	5	30	2	28
M	11	M	5	5	4	5	5	5	4	3	5	3	3	3	29	21	8
N	13	M	5	3	5	4	4	5	0	0	0	0	0	0	26	26	0
O	14	F	5	5	5	5	0	5	1	0	0	0	0	1	25	23	2

1. Self
2. Peer
3. Family
4. Adult Authority
5. Task Performance
6. Social/Emotional

Note: Pre objectives vary according to student need

APPENDIX I

PRE AND POST ACADEMIC ACHIEVEMENT OF STUDENTS BY GRADE LEVEL

Pre and Post Academic Achievement
of Students by Grade Level

			Reading		Math		Spelling	
			Pre	Post	Pre	Post	Pre	Post
Student	Age	Sex						
A	8	M	2.1	3.2	2.7	3.8	1.9	2.7
B	8	M	2.2	3.0	2.2	3.0	k.5	3.1
C	8	M	1.4	2.0	2.2	2.2	1.5	1.5
D	9	F	2.0	2.6	1.5	2.2	1.7	2.4
E	9	M	2.1	2.8	2.0	2.7	1.9	2.6
F	10	F	3.1	4.6	2.5	3.3	3.7	4.5
G	10	M	2.3	3.6	2.7	3.5	2.4	3.1
H	10	M	2.3	3.0	3.1	4.2	1.8	2.5
I	10	M	2.9	3.6	2.3	3.0	1.4	3.7
J	10	M	3.6	4.3	3.7	4.4	3.1	3.7
K	11	M	1.2	1.7	1.7	1.7	1.5	1.3
L	11	M	2.4	3.6	2.1	2.7	2.8	3.5
M	11	M	2.5	3.6	2.4	2.8	2.4	2.7
N	13	M	5.1	8.2	6.1	7.7	4.8	6.2
O	14	F	7.2	12.9	5.3	6.4	10.0	10.7